VIDEOTAPE

In The
District Court of Cleveland County
State of Oklahoma

STATE OF OKLAHOMA, ET AL.,

Plaintiffs,

-vs-

R.J. REYNOLDS TOBACCO CO., ET AL.,

Defendants.

CASE NO: CJ-96-1499L(H)

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DEPOSITION
OF
DR. DAVID BENDITT
October 30, 1998

TRAVELING TRANSCRIPT™

A W R
PROFESSIONALS SERVING PROFESSIONALS
A. WILLIAM ROBERTS, JR. & ASSOCIATES
CHARLESTON (843) 722-8414 COLUMBIA (803) 731-5224
GREENVILLE (864) 234-7030 CHARLOTTE (704) 573-3919
1-800-743-DEPO

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1 IN THE DISTRICT COURT FOR CLEVELAND COUNTY
2 STATE OF OKLAHOMA
3
4 THE STATE OF OKLAHOMA, et al,
5 Plaintiffs,
6 vs. CASE NO. CJ-96-1499L(H)
7 R. J. REYNOLDS, et al,
8 Defendant.
9
10 DEPOSITION OF: DR. DAVID BENDITT
11 DATE: October 30, 1998
12 TIME: 9:39 a.m.
13 LOCATION: Law Offices of
Doherty, Rumble & Butler
14 Suite 3500
150 South Fifth St.
15 Minneapolis, MN 55402
16 TAKEN BY: Counsel for the Plaintiffs
17 REPORTED BY: JOAN M. ANDERSON
RPR
18
19 ----------
20 Computer-Aided Transcription By:
21 A. WILLIAM ROBERTS, JR., & ASSOCIATES
22 Charleston, SC (843) 722-8414 Greenville, SC (864) 234-7030
23 Columbia, SC (803) 731-5224 Charlotte, NC (704) 573-3919
24
25

1 APPEARANCES OF COUNSEL:
2
3 ATTORNEYS FOR THE PLAINTIFFS:
4 SCRUGGS, MILLETTE,
BOZEMAN & DENT, P.A.
5 BY: CHARLES J. MIKHAIL
and LEE E. YOUNG
6 734 Delmas Avenue (39567)
P. O. Drawer 1425 (39568-1425)
7 Pascagoula, MS
(228) 762-6068
8
ATTORNEYS FOR THE DEFENDANT
9 LORILLAD TOBACCO COMPANY:
10 THOMPSON COBURN
BY: RICHARD S. CORNFELD
11 One Mercantile Center
St. Louis, Missouri
12 (314) 552-6000
13
14 (INDEX AT REAR OF TRANSCRIPT)
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19
20
21
22
23
24
25

1 DR. DAVID BENDITT
2 being first duly sworn, testified as follows:
3 EXAMINATION
4 BY MR. MIKHAIL:
5 Q. Good morning, Dr. Benditt.
6 A. Good morning.
7 Q. We met earlier before we got on
8 record. My name is Charles Mikhail, I'm an
9 attorney from Pascagoula, Mississippi, and I'm
10 one of the attorneys who represents the State of
11 Oklahoma and other plaintiffs in the tobacco
12 litigation.
13 I have some questions that I want
14 to ask you today. I don't know how long it will
15 be. I'm going to try to keep it hopefully to
16 half a day if at all possible. We may spill
17 over lunch, but we'll see. Let me just start
18 out by telling you, you probably heard this
19 before since you have testified, and I'm sure
20 your able counsel has told you, but if at any
21 time you don't understand a question, please
22 don't answer it. It doesn't serve you, your
23 counsel, me or anyone else if you answer the
24 question if you don't understand it.
25 So, please ask me to rephrase it or

1 repeat it if you don't understand it.
2 A. I'll do that.
3 Q. Okay. Also, any time you feel like
4 having a break, just let me know.
5 A. Thank you.
6 Q. I try to be faithful in taking a
7 break every hour on the hour, but sometimes
8 witnesses get uncomfortable as far as they want
9 something to drink or need to go to the bathroom
10 or something, so don't hesitate to stop. There
11 are no hard and fast rules.
12 A. That's understood.
13 Q. Let me start by asking you, Dr.
14 Benditt, am I pronouncing your name correctly?
15 A. Yes, you are.
16 Q. Benditt, okay. When were you first
17 approached to be an expert witness in this
18 tobacco litigation by the State of Oklahoma
19 against various tobacco defendants?
20 A. I believe it was sometime in the
21 early to mid spring of this year.
22 Q. Of 1998?
23 A. Correct.
24 Q. Do you remember who approached you?
25 A. No, frankly, I don't.

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Page 5

Q. Was it an attorney?
A. I can't recall. I think it was actually the individual at the university who takes care of all my activities or others' activities related to testifying.
Q. What do you mean, individual at the university? We're talking about the University of Minnesota Medical Center, Medical School?
A. University of Minnesota, right.
Q. Medical school?
A. They do all the, you know, any billing or anything that happens relative to cases such as these, goes through that organization.
Q. Let me make sure that I understand. Are you saying that someone from the University of Minnesota medical school where you're a professor approached you and asked you to be a witness in this tobacco litigation?
A. No.
Q. Okay. Clarify this for me.
A. There's a business office within the university, broader university structure that deals with requests for consultants. On any matter. Legal matters and others, I

Page 6

assume. And any request that's made by anybody to identify a potential expert or consultant in an area goes through that office, and it's from that office that I recall being asked if I would be prepared to testify in this case.
Q. I understand that there are some universities and there are some hospitals and some institutions around the country just from the experience that I've had where consultants or experts in particular fields make it known or place information in the office of the institution that they are available for consultancies.
So, if someone from the outside inquires at the university, look, I need an expert on this field or this area, who would you recommend that I speak to, they provide them with that information. Is this the type of set up you're describing?
A. No.
Q. Okay. Did an attorney for, let's say Lorillad Tobacco Company, whom Mr. Cornfeld represents, contact you and tell you that they wanted you to be an expert witness in the case?
A. Afterwards?

Page 7

Q. No, the first contact you ever had.
A. No.
Q. The first contact you ever had, was it someone who actually was employed by the university, was it an office within the university?
A. That's my understanding, yes.
Q. And do you remember who that person was?
A. No, it was just a lady that works there.
Q. Was she a secretary, an administrative assistant?
A. I think administrative.
Q. You don't recall her name?
A. Not offhand.
Q. And it was in the spring of this year, to the best of your recollection?
A. That's correct.
Q. And what did she tell you?
A. Basically that there was this case going on in Oklahoma, and that the office had been asked for a consultant who might have some knowledge on this topic, would I be interested

Page 8

and available to participate.
Q. And did she tell you who inquired?
A. No.
Q. Did she tell you what topic she was asked to look into?
A. Well, it was specifically related to the tobacco litigations of which there are a variety going on in the country, and that was -- I just assumed that it was the same sort of thing.
Q. Did she tell you that it was in cardiology?
A. I only testify relative to cardiovascular disease. She didn't ask or specify the area, but I wouldn't pretend to try to testified outside of my area of expertise.
Q. What exactly is the name of that office that this lady works in that contacted you? Does it have a name?
A. Yes, it does.
Q. What's the name?
A. University Research Consortium.
Q. University Research Consortium, part of the University of Minnesota Medical School?

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Page 9

A. Not the medical school, to my knowledge.
Q. Just the university?
A. That's my understanding, yes.
Q. All right. And what was your response to this lady's inquiry? Did you express an interest, did you ask for more information, what did you do?
A. No, I said I would be happy to do it. In as much as I had had some already previous experience in this particular topic, it seemed like it would be something that would be appropriate.
Q. Did you know at the time that you felt like this would be an area that you would feel comfortable in testifying and offering your services? Did you know on whose behalf you may be giving testimony?
A. I knew that it was basically on behalf of tobacco companies, but not the specific corporation.
Q. Not a specific tobacco company, but the defense side of the Oklahoma tobacco case, not the plaintiffs' side?
A. Correct.

Page 10

Q. So, I'm assuming she identified that information to you, she told you when she talked to you that it was testifying for the tobacco industry, correct?
A. That's correct.
Q. And when you expressed an interest to her, or expressed to her an interest, what was the next step? Did she contact someone to get in touch with you? Just tell me how it happened.
A. I can't tell you what she did. All I can say is from my perspective, I was contacted somewhat later by one of the members of the legal team that is obviously working with the defendants, and that's --
Q. That was the next contact?
A. That was the next contact.
Q. Okay. A lawyer?
A. Yes.
Q. Do you remember the lawyer's name?
A. I believe it was Chris Johnson's office.
Q. Who is Chris Johnson, if you know? Is he a lawyer in Minneapolis? If you know. I'm not trying to let you guess.

Page 11

A. I won't -- I don't have an answer to that.
Q. But, Chris Johnson, to the best of your recollection, was an attorney?
A. Yes.
Q. You don't know if he was in Minneapolis or outside the state?
A. Outside the state.
Q. Outside the state. Do you remember what firm he was with?
A. No.
Q. Was it Thompson Coburn, the same law firm that Mr. Cornfeld is from?
A. No.
Q. Was it Shook, Hardy and Bacon?
A. I think so.
Q. Kansas City sound familiar?
A. Yes, it does.
Q. And did you and Mr. Johnson meet to discuss your prospective or potential testimony in the case?
A. We had met, yes.
Q. And where did you meet?
A. We've met basically in two places. We met initially in my office at the university,

Page 12

and subsequently at a hotel conference room.
Q. So, you've met with him twice?
A. In total, probably four or five times.
Q. Four or five times. The first meeting you had with him, was anyone else present other than Mr. Johnson? Assuming that's the proper name. You sound like you're not sure that that's the name. If that's the proper name, did you meet with him or someone else?
MR. CORNFELD: That's the right name.
A. You're right, I would be very embarrassed not to have the right name of someone I talked to several times, but there were a number of other attorneys present at the time.
BY MR. MIKHAIL:
Q. The first meeting?
A. I believe that's correct, yes.
Q. Dr. Benditt, this first meeting with Mr. Johnson and others, do you remember who the others were?
A. Well, I think Mr. Cornfeld was there, and there were two other attorneys whose

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Page 13

1 names I don't recall at the present time.
2 MR. MIKHAIL: He remembers your
3 name, Rick.
4 MR. CORNFELD: I wasn't even
5 mouthing it to him.
6 A. It does become confusing as I'm
7 sure you understand with the various people that
8 are involved.
9 BY MR. MIKHAIL:
10 Q. No, I understand completely. Let
11 me ask you, Dr. Benditt, do you recall
12 specifically what either Mr. Johnson or Mr.
13 Cornfeld or any one of the attorneys who met
14 with you in that first meeting, what they told
15 you about what they wanted from you? In other
16 words, did they tell you what your mission was
17 or what the purpose of your coming on board as
18 an expert witness in the case was for?
19 A. Yes, my mission, as you put it, was
20 basically to tell whoever was interested,
21 yourself and juries if necessary, my views on
22 the relationship between tobacco smoking and the
23 occurrence of cardiovascular manifestations of
24 disease.
25 Q. Did any one of them at the meeting,

Page 14

1 at that first meeting, express to you what their
2 client, tobacco manufacturers' position was on
3 the relationship between smoking and
4 cardiovascular disease?
5 A. No.
6 Q. Did you at the time that you met
7 with them know what the position of the tobacco
8 manufacturers whom these lawyers represented was
9 on the relationship between smoking and
10 cardiovascular disease?
11 A. Not in specific terms. I had a
12 general inclination, or my intuition, but that's
13 about it.
14 Q. That intuition, or that general
15 inclination, as you described it, did it
16 coincide with the views that you had?
17 A. All I can say is that my views are
18 very specifically related to the literature. My
19 intuition is that in some respects, maybe in
20 many respects, our views cross, but I can't say
21 what all of their views are, so I can't answer
22 that question.
23 Q. The general inclination or general
24 idea that you had before you met with them about
25 what the tobacco industry, and I'm going to use

Page 15

1 the word tobacco industry, that's probably not
2 as clear to define, but just to make it easier,
3 I'm referring specifically to the defendants in
4 this litigation, but the tobacco industry, what
5 was the view of the tobacco industry?
6 You said you had a general idea or
7 general inclination of what their view was as to
8 the relationship between smoking and
9 cardiovascular disease. What was that
10 position?
11 MR. CORNFELD: Charles, let me
12 object.
13 MR. MIKHAIL: It's a long question,
14 I know.
15 MR. CORNFELD: Right, and also just
16 object to the use of the term tobacco industry.
17 But, subject to that.
18 BY MR. MIKHAIL:
19 Q. Let me just say that, and say
20 tobacco manufacturers as well as their trade
21 associations, the tobacco institute.
22 A. Essentially, nobody in any of these
23 meetings or other places ever expressed to me
24 the specific views of the various organizations
25 that you've mentioned. The sense of the

Page 16

1 meetings and my own position would be that I
2 simply report my position with respect to how I
3 base it on the literature that I am aware of,
4 and if that view happens to coincide with other
5 people's views, so be it, and if it doesn't
6 coincide with other people's views, that's too
7 bad. But, that's the only way that I would
8 present information in a case such as this.
9 Q. I understand that, Dr. Benditt, but
10 what I'm saying is, you testified earlier, if I
11 understood you correctly, that before you even
12 met with them or when you met with them, without
13 them expressing the tobacco manufacturers and
14 the tobacco institute's view, you had a general
15 idea or a general inclination of what their view
16 was on the relationship between smoking and
17 cardiovascular disease, and I'm asking you what
18 was that inclination you had as to what their
19 position was?
20 A. Okay, I think I understand your
21 question better now. It's more or less my view
22 of what their position is, or was, probably
23 similar to anybody that reads the newspapers and
24 watches television in this country, and that is
25 that their position would be that tobacco has

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Page 17

1 not been proven to be the cause of
2 cardiovascular disease, and the general sense of
3 its relationship to diseases, particularly in my
4 case, cardiovascular disease --
5 Q. In your field.
6 A. -- Is intermingled with many other
7 factors that smokers may have, and consequently,
8 it is difficult to identify in quantitative
9 terms any specific additional risk that smokers
10 might have vis-a-vis cardiovascular disease.
11 Q. That was generally your
12 understanding of what their position was?
13 A. That's my understanding of what
14 their position was.
15 Q. When you went into that meeting
16 with that understanding, did that understanding
17 coincide generally, we're going to get into
18 specifics, but generally with your views?
19 A. Yes.
20 Q. When you met with these
21 individuals, did they ask you what your opinion
22 was on the relationship between smoking and
23 cardiovascular disease?
24 A. I'm sure they did.
25 Q. You don't specifically recall?

Page 18

1 A. No, I don't.
2 Q. But, as a result of the meeting,
3 was there a meeting of the minds, was there an
4 agreement that you would in fact testify for
5 their clients?
6 A. Yes, there was.
7 Q. Do you know, Dr. Benditt, if the
8 tobacco manufacturers and the tobacco institute
9 in the Oklahoma tobacco litigation approached or
10 requested expert testimony from any other
11 specialist in the same field that you have
12 expertise in, which expert turned them down?
13 A. No, I don't.
14 Q. None of your colleagues, to your
15 knowledge, were approached and refused to
16 testify?
17 A. Not to my knowledge, no.
18 Q. Let's go to this initial meeting
19 that you had with the several people, Chris
20 Johnson and Mr. Cornfeld and others, or at any
21 other meeting that you had with them. Did they
22 solicit or ask you for an opinion that you could
23 not agree with or did not agree with?
24 A. No, they did not.
25 Q. I'm going to make it easier

Page 19

1 time-wise here. On May 1, 1991, May 1 of this
2 year, the defendants that we're talking about
3 were required under the court order in the
4 Oklahoma case, Mr. Cornfeld can verify this, to
5 submit a disclosure statement summarizing
6 basically what your testimony was going to be,
7 and it's something, actually, it's not
8 necessarily something you would have to draft,
9 but it was a disclosure statement which we'll
10 get into, along with a curriculum vitae. We had
11 to exchange. They had to give them to us. We
12 gave them ours earlier in February. So, keeping
13 in mind the date of May 1, 1998 when they
14 provided this material to us, have you met with
15 any attorney, whether it's Chris Johnson, Mr.
16 Cornfeld, since May 1 of 1998?
17 MR. CORNFELD: Let me just say, you
18 said I can verify the date. I don't really
19 recall.
20 MR. MIKHAIL: I'll represent that
21 it was May 1.
22 MR. CORNFELD: That's fine with
23 me. I personally don't recall the exact date.
24 MR. MIKHAIL: It's in my noodle. I
25 remember.

Page 20

1 BY MR. MIKHAIL:
2 Q. If my representation is correct,
3 Dr. Benditt, and I represent to you that it is,
4 under the court order, the defendants provided
5 us with the disclosure statement what your
6 testimony was going to be along with your
7 curriculum vitae, May 1, 1998. We are now what,
8 October 30. Since May 1, have you had any
9 meetings with any attorney for the tobacco
10 manufacturers or the tobacco institute?
11 A. Yes.
12 Q. Do you remember how many?
13 A. I think I said earlier, four or
14 five, in that ball park.
15 Q. And what transpired at the
16 meetings?
17 A. Essentially I presented papers
18 related to the topic of smoking, tobacco use and
19 cardiovascular disease in a broad range of
20 categories, and we discussed those papers and my
21 interpretation of those papers and how they
22 might relate to the specific topic of this
23 litigation.
24 Q. When you say papers, are we talking
25 about like journal articles and excerpts of

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Page 21

1 books and that sort of thing?
2 A. That's correct, yes.
3 Q. I'm assuming you're charging them
4 fees for your services; is that right?
5 A. Yes. As I pointed out earlier,
6 that's done through the university system, and
7 --
8 Q. And how much are you charging them?
9 A. My recollection is that it's $300
10 per hour, but I'm not exactly sure. But, it's
11 in that ball park.
12 Q. Dr. Benditt --
13 MR. CORNFELD: Let me just also
14 object. Your question was how much are you
15 charging him. The university is really doing
16 the charging.
17 MR. MIKHAIL: I'm going to clarify
18 that because we've encountered that with many
19 professors.
20 BY MR. MIKHAIL:
21 Q. As Mr. Cornfeld pointed out, when I
22 say you're charging them, that's the charge for
23 your services, to the best of your recollection,
24 $300 an hour; is that correct?
25 A. That's correct, and anticipating

Page 22

1 your next question, I probably receive about
2 half of that.
3 Q. So, actually, you're not setting
4 the fee at 300?
5 A. No, I'm not. That's a fairly
6 standard fee that the office has.
7 Q. The university.
8 A. Correct.
9 Q. And you receive approximately half
10 of that amount?
11 A. Correct.
12 Q. Do you know just offhand, Dr.
13 Benditt, how much time you have spent, how many
14 hours you've spent since first contacted?
15 A. No, I don't.
16 Q. Is it under or more than 50 hours?
17 A. It's probably under 50 hours.
18 Q. Under 50? Okay. Have you received
19 money for the time you've spent so far?
20 A. Yes, I have.
21 Q. And who actually sends you the
22 money? Does the university send you the money?
23 A. That's correct.
24 Q. I noticed in the disclosures that
25 Mr. Cornfeld sent to me last week, actually,

Page 23

1 sent to someone else who sent them to me, but
2 that's not important, that you listed several
3 cases in which you recall maybe giving
4 depositions or trial testimony, so I'm assuming
5 that you've given depositions before?
6 A. I have, yes.
7 Q. And have you testified at trials
8 before?
9 A. I have.
10 Q. Do you recall what subject matter
11 you testified about in deposition and in trial?
12 A. I can give you some examples.
13 There may be others that I've forgotten.
14 Q. We'll go through the list Mr.
15 Cornfeld provided, but let me just ask you
16 generally, was it all in your area of expertise
17 on cardiovascular disease?
18 A. Yes.
19 Q. Do you recall if they were for the
20 plaintiff's side or the defendant's side?
21 A. Sometimes one, sometimes the other.
22 Q. Mixture?
23 A. Correct.
24 Q. Okay. In any of those cases, did
25 you ever give testimony on the issue of what

Page 24

1 caused cardiovascular disease in a particular
2 individual, whether you were representing the
3 defendants or the plaintiff? Was the issue what
4 caused some form of cardiovascular disease in a
5 particular individual?
6 A. The principal issue was never that,
7 to my recollection. I may have made statements
8 about my opinion as to what might have caused
9 the disease in that particular individual, but I
10 think that was never the central point of the
11 litigation.
12 Q. Do you recall any of the testimony
13 you gave by deposition or trial actually being
14 focused on the issue of what caused
15 cardiovascular disease in the patient?
16 A. If we exclude the Minnesota
17 Attorney General case --
18 Q. Exclude that?
19 A. Then I don't think that there were
20 any that really dealt with that issue in any
21 detail.
22 Q. And that would include whether or
23 not smoking caused cardiovascular disease?
24 A. That's correct.
25 Q. Did you testify in any cases

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1 involving injuries as a result of exposure to
2 asbestos?
3 A. No, I haven't.
4 Q. Have you read depositions of any
5 expert witnesses? I'm not talking about
6 Medicaid recipients from Oklahoma, I'm talking
7 about expert witnesses in the Oklahoma tobacco
8 case in preparation for this deposition or
9 before we are deposing you today?
10 A. Yes.
11 Q. Can you identify which experts
12 whose depositions you read?
13 A. Specifically Doctors Ralph Lazzara
14 and Dr. Whitsett, I believe.
15 Q. I believe Dr. Whitsett is a
16 peripheral vascular specialist?
17 A. That's my understanding.
18 Q. And Dr. Lazzara is a cardiologist?
19 A. Correct.
20 Q. Have you read the deposition of Dr.
21 Henry Blackburn?
22 A. Indeed, yes, I did look at that as
23 well.
24 Q. Do you remember if you read the
25 deposition of Dr. Henry Blackburn only in the

1 Oklahoma case or any depositions of his that he
2 gave in other cases, if you know.
3 A. My understanding was it was related
4 to the Oklahoma case, but now that you mentioned
5 it, I can't be absolutely sure I recall that.
6 Q. Do you know Henry Blackburn?
7 A. I certainly know who he is. He's
8 not a personal friend, but he's very well-known
9 in this area of the country, as you might
10 expect.
11 Q. Have you met him?
12 A. Yes.
13 Q. You don't have any kind of social
14 relationship with him or anything?
15 A. No, I don't.
16 Q. What about professionally, do you
17 all have any occasion to interact on a
18 professional level?
19 A. No, not really. His area of
20 expertise is both intellectually and somewhat
21 physically removed in the sense that their
22 offices are considerably at some distance from
23 ours. So, we don't cross paths, and he's, as I
24 understood, somewhat semi-retired.
25 Q. As of recently?

1 A. Yes.
2 Q. Okay. To the best of your
3 recollection, Dr. Benditt, are there any other
4 expert depositions you've read other than
5 Whitsett, Lazzara or Blackburn?
6 A. I don't recall any others.
7 Q. If during the day you recall any
8 others, would you just volunteer that
9 information?
10 A. I will.
11 Q. Have you looked at any list of
12 opinions of any expert in this case, not
13 deposition testimony, but a piece of paper or a
14 few pages that actually lists opinions to be
15 given by any particular experts in this case?
16 A. No, I have not.
17 Q. How about disclosure statements?
18 And I mean by that, just a page or two that
19 says, disclosure statements for Dr. Benditt's
20 testimony, or whoever the expert is, do you
21 recall reading any disclosure statements?
22 A. Other than my own, I don't recall
23 reading any.
24 MR. MIKHAIL: Could you mark this
25 as Exhibit 1, please?

1 EXAMINATION
2 (Whereupon, Deposition Exhibit No.
3 1 was marked for identification and a copy is
4 attached and hereby made a part of this
5 deposition.)
6 BY MR. MIKHAIL:
7 Q. Dr. Benditt, I'm going to hand you
8 what's been marked as Exhibit 1. I'll hand you
9 an exhibit that's been marked Benditt 1, and
10 that has been represented to me by Mr. Cornfeld
11 to be a current version of your curriculum
12 vitae. Can you verify that?
13 A. Yes, that is correct.
14 Q. Earlier you heard us talk before we
15 got on record that we had received a copy of a
16 curriculum vitae in May, and then another one
17 in, well, a week or so ago, that appeared to be
18 outdated. Let's put those aside. The one we're
19 working from is the one that was handed to me
20 today and marked Exhibit 1. This is the most
21 current curriculum vitae, if I understand
22 correctly, that you have; is that right?
23 A. Essentially, yes. I think that CVs
24 are an electronic media and they can sort of get
25 updated by the hour, but I think for practical

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Page 29

1 purposes, this is quite current.
2 MR. CORNFELD: I'm not sure Dr.
3 Benditt knows this, but it was printed out by
4 his secretary yesterday, so it was certainly up
5 to date, or should have been, as of that
6 minute.
7 BY MR. MIKHAIL:
8 Q. Do you know, Dr. Benditt, why a
9 current curriculum vitae was not provided us on
10 May 1, 1998?
11 MR. CORNFELD: Object to the form.
12 Object, lack of foundation. I'm not sure
13 whether that was current or not as of that
14 time.
15 MR. MIKHAIL: I'm asking whether he
16 knows. That's fine.
17 BY MR. MIKHAIL:
18 Q. Were you requested by counsel,
19 either Mr. Cornfeld or anyone else, to provide
20 in the spring of this year, when you were
21 contacted and agreed to testify, were you asked
22 for a current curriculum vitae?
23 A. Yes, I believe I was.
24 Q. And the curriculum vitae that you
25 provided them we now know was not current. Can

Page 30

1 you explain that?
2 MR. CORNFELD: I'm not sure that's
3 right. I know it says April, '94.
4 MR. MIKHAIL: Well, it says May,
5 '94, but the one I've been provided today was
6 so different than --
7 MR. CORNFELD: It may be, but that
8 doesn't mean that what you were provided last
9 May, I mean, did it have anything in there from,
10 since 1994?
11 MR. MIKHAIL: Well, let me put it
12 this way --
13 MR. CORNFELD: All I can say is --
14 MR. MIKHAIL: No, I understand
15 that. I don't mean to interrupt you, but the
16 curriculum vitae that was given to us even as of
17 last week, which is the seven days disclosure,
18 was the same one that was given to us in May,
19 and it is markedly different than the one
20 presented today. I'm not making an issue of
21 it. I'm trying to understand whether or not--
22 MR. CORNFELD: All we did, we just
23 attached the curriculum vitae that we had at
24 that time to the seven day disclosure and
25 probably didn't even realize that it was at

Page 31

1 least as old as last May or didn't think about
2 it until getting ready for the deposition, when
3 we realized we needed one that was up to date.
4 MR. MIKHAIL: I understand that.
5 I'm not trying to quibble with you, it's just
6 there are a number of things on Benditt 1 today
7 that I have not had a chance to examine, but
8 also that are this document that were not on the
9 CV that was provided us, so I wanted to ask you
10 a series of questions so I can make my record
11 and understand. Were you requested in April of
12 1998 to provide a copy of your then current CV?
13 A. Yes, I suspect I was.
14 Q. And the one that you provided in
15 April or early May of 1998 contained information
16 less than the Benditt one that we have today,
17 correct?
18 A. If you say so. I have no reason to
19 disagree with you.
20 MR. MIKHAIL: I'm going to hand the
21 court reporter, ask to mark this as Exhibit 2,
22 please.
23 (Whereupon, Deposition Exhibit No.
24 2 was marked for identification and a copy is
25 attached and hereby made a part of this

Page 32

1 deposition.)
2 BY MR. MIKHAIL:
3 Q. Dr. Benditt, Exhibit Benditt 2 that
4 I've handed you, would you take a moment and
5 look at it and tell me if this CV was current as
6 of May 1 of 1998.
7 A. With respect to my demographic
8 data, positions, and you know, academic
9 appointments, professional societies, etc., --
10 Q. I think the difference is comparing
11 them with publications and books.
12 A. All of that, the first part is the
13 same. The second part with respect to peer
14 reviewed publications, I think that there's
15 probably been a number more. It shows that
16 we've done some work since this one was
17 published, and in terms of abstracts, I think
18 there's probably a few more, as well.
19 Q. Is Benditt 2, was it current on May
20 1 of '98?
21 A. Yes, in the sense that we don't
22 print these out very often because they're much
23 too lengthy and costly to print out, so we keep
24 a couple in the file, and if somebody requests a
25 CV, usually what they're really interested in is

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Page 33

1 the first three pages, so it never has been an
2 issue for us. We just pull out the one that
3 we've last printed up. And if somebody really
4 wants the most recent publications, they will
5 ask for it.
6 Q. Did counsel ask you for a current
7 CV by May 1 of 1998?
8 A. I'll put it this way. They asked
9 for a CV. Whether they used the term current CV
10 by May 1 of 1998, I can't answer.
11 Q. Is my understanding so the record
12 will be clear, Dr. Benditt, is my understanding
13 to the best of your recollection Benditt 2 was
14 current as of May 1, 1998?
15 MR. CORNFELD: Object to the
16 repetitious form of the question. He explained,
17 and I think it was clear what it was as of May,
18 1998, and what he meant when he said it was
19 current as of that time.
20 MR. MIKHAIL: I understand. He
21 said it was current in the sense that he ran it
22 off for you.
23 MR. CORNFELD: No, that he had it
24 in the file. He keeps old ones in the file and
25 he hands them out when people ask for them, but

Page 34

1 he doesn't print new ones out very often off his
2 computer.
3 BY MR. MIKHAIL:
4 Q. As of May 1, 1994, you had various
5 publications that you had published and existed
6 that don't in fact appear on Benditt 2, correct?
7 A. Your question just specified May 1
8 of 1994, and this CV is dated May 1 of 1994.
9 Q. Not '94, 1998. As of May 1, 1998,
10 Benditt 2 is what was provided us on May 1 of
11 1998, and I'm asking you, were there articles or
12 books or abstracts or any form of publications
13 or work in which you had taken part, whether
14 they were abstracts, books, publications, etc.,
15 that were in existence on May 1, 1994, that
16 don't in fact appear on Benditt 2?
17 A. May 1, 1998.
18 Q. 1998, I'm sorry.
19 A. It's not my job to correct you --
20 Q. Correct me, please.
21 A. You said twice already, May, 1994,
22 and up to May, 1994, this is absolutely
23 current. It was the one that we keep in the
24 file for general purposes because as a general
25 rule, when people ask for my CV such as for

Page 35

1 lectures or visiting professor appointments and
2 whatnot, really what they care about is the
3 first three pages, and that hasn't changed.
4 But, in terms of the specific
5 additional publications, there were a number of
6 additional publications that do not appear in
7 the Benditt 2 exhibit that are now represented
8 in the Benditt 1 exhibit.
9 Q. And existed on May 1, 1998?
10 A. Yes, that is true.
11 MR. MIKHAIL: Could you mark this,
12 please, as the next exhibit.
13 (Whereupon, Deposition Exhibit No.
14 3 was marked for identification and a copy is
15 attached and hereby made a part of this
16 deposition.)
17 BY MR. MIKHAIL:
18 Q. Dr. Benditt, I really don't want to
19 belabor the point, but it's important to
20 establish the record as far as we're concerned.
21 Benditt 3 has been marked, and if you'll look at
22 the right-hand side at the top, Rick, I wrote in
23 my handwriting, "With disclosure."
24 MR. CORNFELD: With recent
25 disclosure.

Page 36

1 BY MR. MIKHAIL:
2 Q. With recent disclosure. I'll
3 represent to you that Benditt 3 was a document
4 that was FAXed to plaintiff's counsel about a
5 week or ten days ago, I suppose.
6 MR. CORNFELD: It shows October
7 23rd it was FAXed by my office.
8 BY MR. MIKHAIL:
9 Q. A week ago. And to the best of my
10 ability, I compared it to Benditt 2, which was
11 provided us on May 1 of this year, of 1998.
12 They appear to be identical. If you could
13 verify that for me.
14 MR. CORNFELD: Charles we don't
15 need to take the time out. If you say you
16 compared them and they're identical, that's good
17 enough. I'm sure what we did is we just had the
18 CV we had in the file and we had to attach it to
19 the 7 day disclosure, so we just attached the
20 same one, not even thinking about whether it was
21 up to date.
22 BY MR. MIKHAIL:
23 Q. Okay. Did counsel ask you between
24 May 1 of 1998 and October 23 of 1998 when
25 Benditt 3 was FAXed to us, did they ask you for

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Page 37

1 a more current CV?
2 A. I don't believe.
3 Q. Today we were furnished with
4 Exhibit 1, Benditt 1, which is, according to
5 your testimony, a current CV; is that correct?
6 A. Well, it's currently dated July,
7 1998, and frankly, the way our group produces
8 academic materials, I wouldn't say that it's
9 current to this minute. But, it's current up
10 until a reasonable period of time ago.
11 Q. And when did counsel request that
12 you run off what we now have marked as Benditt
13 1?
14 A. I believe the request came
15 yesterday and it was undertaken yesterday.
16 Q. Thank you, Dr. Benditt. Do you
17 want to take a short break?
18 THE VIDEOGRAPHER: Going off the
19 video record. The time is now approximately
20 10:19 a.m. Elapsed time is 39, 38.
21 (WHEREUPON, A BRIEF RECESS WAS HAD).
22 THE VIDEOGRAPHER: We're back on
23 the video record. The time is now approximately
24 10:32 a.m. Elapsed time is 52, 51.
25 MR. MIKHAIL: Do you want to put

Page 38

1 something on the record?
2 MR. CORNFELD: Yes, I want to
3 clarify something about the CV that was provided
4 in May of this year with the initial
5 disclosure. I believe that is the same CV that
6 was provided for Mr. Benditt in the Minnesota
7 attorney generals case in which he testified
8 some time ago. There was, and what we did was,
9 we just attached it. We had that CV in our
10 file, and we just attached it to the
11 disclosure. There certainly could not have been
12 any attempt to be deceptive about it since the
13 CV clearly states on the first page that it is
14 dated May, 1994, and in fact, I've looked
15 through it and there are no publications listed
16 after May, 1994, so it's not like we tried to
17 omit publications that would have been on a CV
18 if it had been printed out and up to date as of
19 May of this year.
20 MR. MIKHAIL: And for the record,
21 Dr. Benditt, and you, Rick, I was not in any way
22 and do not now suggest that anyone was trying to
23 be deceptive or deliberately withhold anything.
24 I was simply trying to make the record as to
25 what was provided. I would not do that, Rick.

Page 39

1 We've practiced together a number of times, and
2 I would not do that.
3 BY MR. MIKHAIL:
4 Q. Would you state your name for the
5 record, please?
6 A. My name is David Benditt,
7 B-e-n-d-i-t-t.
8 Q. The most important question in the
9 deposition. Dr. Benditt, would you take a look
10 at Benditt 1, which is the CV that was provided
11 us this morning. I'm going to be asking you
12 just a few questions about this, but I'm going
13 to be working from one of the other CVs, but
14 it's not going to make a difference, because I
15 already jotted down in my own handwriting some
16 questions that I have not had a chance to
17 transfer on to the new copy of the CV. Let me
18 ask you this: Tell me exactly what your
19 specialty is. What are you an expert in?
20 A. I'm a specialist in cardiovascular
21 disease, particularly expert in the evaluation
22 of heart rhythm disturbances.
23 Q. Are you a cardiologist?
24 A. Yes.
25 Q. Are you a cardiovascular surgeon?

Page 40

1 A. No.
2 Q. You are not a surgeon at all?
3 A. Correct.
4 Q. A cardiologist, even though they
5 are not surgeons, to my understanding, do some
6 invasive procedures like pace makers and
7 angioplasty?
8 A. Correct.
9 Q. And some others. Do you do
10 invasive procedures?
11 A. In that sense, I do, yes, I do.
12 Invasive procedures, heart catheterization,
13 particularly related to rhythm disturbances, but
14 also for pressure measurements inside the heart
15 and things of that nature. I do do minor
16 surgical procedures as you alluded to for the
17 implantation of pacemakers, implantable
18 defibrillators, implantable loop recorders and
19 other minor surgical procedures that might go
20 along at the same time as these.
21 Q. But you are not presenting yourself
22 as an expert and do not plan to give expert
23 testimony in this case as a cardiovascular
24 surgeon?
25 A. That's correct.

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Page 41

1 Q. And I know that peripheral vascular
2 surgery is part of cardiovascular surgery, but
3 do you put yourself out or are you presenting
4 yourself out in this case as an expert in
5 peripheral vascular surgery?
6 A. No, I am not.
7 Q. How about thoracic surgery?
8 A. No.
9 Q. Tell me what a cardiovascular
10 researcher is.
11 A. Cardiovascular researcher is a very
12 broad term. It could be an individual who does
13 very basic cellular research and molecular
14 research or clinical research in the broad field
15 of cardiovascular disease, and that could
16 encompass probably several hundred, if not more
17 elements or possibilities.
18 Q. Are cardiovascular researchers
19 cardiologists?
20 A. Not necessarily. Cardiovascular
21 researchers might have any of a variety of
22 background training and skills.
23 Q. Would epidemiology be one?
24 A. Yes.
25 Q. Is it a necessary discipline for a

Page 42

1 cardiovascular researcher to be an
2 epidemiologist?
3 A. No.
4 Q. In looking at your CV, I notice
5 you've been in practice approximately 25 years
6 or so; is that correct?
7 A. More or less. 20 years at the
8 University of Minnesota, another five plus years
9 in specialty training.
10 Q. In your work, Dr. Benditt, do you
11 actually treat patients?
12 A. Oh, yes.
13 Q. About how many patients do you
14 treat a year, just an approximation?
15 A. It's probably easier for me to
16 break it down by the week. I would say probably
17 close to 20 patients per week, so you could
18 multiply that out.
19 Q. Is that, and I know it spans over
20 more or less 25 years, but is that number close
21 for all the years that you've been in practice?
22 A. Yes, I think that's a fair
23 estimate. Obviously by being in an academic
24 practice, I might at various times be doing more
25 research than clinical care, but if we smooth

Page 43

1 that out over the course of the year, it's
2 probably about 20 patients a week.
3 Q. So, you are considered a practicing
4 cardiologist?
5 A. Oh, yes.
6 Q. Notwithstanding the fact that you
7 are a professor at the medical school?
8 A. That's correct.
9 Q. Well, I just want to make sure we
10 understand. Dr. Benditt, you are connected with
11 the university medical school, correct?
12 A. That's correct.
13 Q. Are you required to seek either
14 permission or at least inform the university
15 when you are retained as a consultant or as an
16 expert witness?
17 A. No, I'm not.
18 Q. You don't know of any rule or law
19 or any sort of contractual provision that you
20 have with the university that requires you to
21 disclose outside consultancies?
22 A. Outside consultancies related to
23 ongoing activities such as consultancies for
24 pharmaceutical firms, device manufacturers.
25 Basically that form is disclosed annually.

Page 44

1 Consultancies related to appearing in legal
2 cases --
3 Q. As an expert witness?
4 A. As an expert witness, does not fall
5 in that category.
6 Q. Okay. When you are consulted to be
7 an expert witness, is there a process by which
8 you go through a conflicts check? Do you know
9 what a conflicts check is?
10 MR. CORNFELD: Object to the form.
11 BY MR. MIKHAIL:
12 Q. Do you understand my question?
13 A. Yes. I understand your question,
14 but I'm not specifically certain as to how you
15 define a conflicts check.
16 Q. For instance, you were at least
17 provided some service in connection with the
18 State of Minnesota's tobacco litigation,
19 correct?
20 A. That's correct.
21 Q. And you are connected with the
22 University of Minnesota Medical School, correct?
23 A. That's correct.
24 Q. Were you required to disclose to
25 the university that you were retained as an

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Page 45

1 expert against the State of Minnesota, for
2 instance? That's the type of conflict I'm
3 talking about.
4 A. I don't believe I was required to
5 disclose that, but it was common knowledge.
6 Q. So, you don't recall actually
7 filing a form or notifying the office of the
8 university medical school officially that you
9 were testifying opposite the State of Minnesota?
10 A. No, I did not.
11 Q. Did anyone connected with the
12 university bring that to your attention, or
13 point out to you any problem or any conflict?
14 A. No. And a number of other
15 university employees were similarly engaged in
16 that process and it didn't seem to be an issue
17 with the university.
18 Q. When you were in medical school,
19 Dr. Benditt, what did they teach you, what were
20 you taught about the causal relationship between
21 smoking and various forms of cardiovascular
22 disease?
23 A. The standard medical school
24 teaching is that cardiovascular disease is
25 caused by a number of factors, including

Page 46

1 smoking.
2 Q. So, in medical school, among other
3 causes, you were taught that smoking causes
4 cardiovascular disease, correct?
5 A. That's correct.
6 Q. And in the hospitals in which you
7 have worked, and you have an illustrious list of
8 places that you have worked, teaching hospitals
9 and others, what generally was the view among
10 experts of your same specialty as to smoking and
11 a causal relationship with cardiovascular
12 disease at those hospitals?
13 A. I can't express what the view of
14 experts was. I can only express what the view
15 of individuals were, and I can't assess their
16 degree of expertise.
17 Q. Let me ask the question this way.
18 Among your colleagues at those hospitals among
19 the same specialties that you have, what was the
20 generally accepted medical view as to the causal
21 relationship between smoking and various forms
22 of cardiovascular disease?
23 MR. CORNFELD: Object to the form.
24 BY MR. MIKHAIL:
25 Q. You may answer.

Page 47

1 A. I think if you asked you would
2 probably find that it would be the standard
3 response that you had received from the medical
4 school training, that among the various factors
5 that cause cardiovascular disease, smoking is
6 there.
7 Q. You are a professor of medicine,
8 correct?
9 A. Correct.
10 Q. And you teach, am I correct to say,
11 cardiology?
12 A. That's correct.
13 Q. What do you teach your students --
14 are they properly called students, or are they
15 properly called interns or residents or what?
16 A. There may be a whole host of them.
17 There may be medical students, undergraduate
18 students and also postgraduate students which
19 would include residents, interns and other even
20 more advanced sub-specialty trainees.
21 Q. Those whom you teach, how is that?
22 A. That's fine.
23 Q. What do you teach them as a
24 professor of medicine and a cardiologist, what
25 do you teach them as to the causal relationship

Page 48

1 between smoking and various forms of
2 cardiovascular disease?
3 A. Basically my teaching is that
4 smoking is a risk factor for cardiovascular
5 disease, but that the demonstration of a causal
6 relationship is not there.
7 Q. So, you don't teach them that
8 smoking is one cause of cardiovascular disease?
9 A. That's correct.
10 Q. Outside teaching hospitals or
11 medical school, have you practiced cardiology in
12 private practice?
13 A. All my practice has been through
14 teaching hospitals, although to be fair, my
15 practice includes a large, what we call outreach
16 components, which is a community based
17 cardiology component, which is included a
18 variety of community hospitals, both in the Twin
19 Cities and the outer parts of the State of
20 Minnesota.
21 Q. And I understand that. I'm just
22 trying to find out your background. Have you
23 ever been in private practice of cardiology?
24 A. No, not in private practice as it's
25 commonly understood.

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1 Q. Dr. Benditt, we talked about what
2 you were taught in medical school about
3 causation. We talked about what was the
4 generally accepted view in the hospitals with
5 which you were affiliated over the years, and
6 we've talked about what you teach your students
7 about causal relationship as a professor of
8 medicine here at the University of Minnesota.
9 I'm going to ask you what is taught by your
10 colleagues at the University of Minnesota
11 medical school of a similar specialty of yours
12 about causation between smoking and
13 cardiovascular disease.
14 MR. CORNFELD: Object to the form
15 of the question, and in particular, to the long
16 preface, which didn't explicitly purport to
17 restate the witness's testimony, but to the
18 extent it could be regarded as doing so, I think
19 misstates the testimony. Subject to that, you
20 can answer.
21 MR. MIKHAIL: Your object is
22 noted.
23 BY MR. MIKHAIL:
24 Q. Did you understand the question?
25 A. I did understand the question, and

1 in as much as it relates to what other people
2 teach, I can't answer that question.
3 Q. But, do you know what the generally
4 accepted view is at the University of Minnesota
5 medical school by your colleagues as to the
6 causation issue between smoking and
7 cardiovascular disease?
8 MR. CORNFELD: Object, lack of
9 foundation and object to the form of the
10 question.
11 BY MR. MIKHAIL:
12 Q. You may answer.
13 A. Once again, there's never been any
14 specific survey taken, and I certainly haven't
15 taken it with respect to trying to give you an
16 answer that I can say categorically this is what
17 the view is, but my hunch, and it's strictly a
18 hunch, is that the prevailing view is that
19 there's a causal relationship between smoking
20 and cardiovascular disease, because that's what
21 the conventional teaching is.
22 Q. Are you the only cardiologist or
23 professor of medicine at the University of
24 Minnesota who holds the view that you have as to
25 the causal relationship between smoking and

1 cardiovascular disease?
2 A. I can't answer that. I don't know,
3 I might be. But, probably not.
4 Q. Can you name anyone else who has a
5 view similar to yours?
6 A. No, I can't name others.
7 Q. Are you an epidemiologist?
8 A. No.
9 Q. Are you presenting yourself in this
10 case as an expert in epidemiology?
11 A. No.
12 Q. Your board certification is in
13 cardiology, correct?
14 A. Correct.
15 Q. And you have on your CV that your
16 certification, or specialty certification is
17 cardiac pacing. Is that a proper term?
18 A. That's a subsidiary certification
19 or license, if you will, license in the sense
20 that that is a different examination. It's
21 really a testamur for special proficiency in
22 that area.
23 Q. Excuse my ignorance. I practice
24 law. Once in awhile I dabble in the medical
25 field. Is cardiac pacing a field that you get

1 Board certified in or is it something included
2 in board certification for cardiology?
3 A. That's a controversial area in
4 cardiovascular medicine right now, but I think
5 the general sense is that if you're Board
6 certified in cardiovascular medicine, you can
7 undertake cardiac pacing and related sciences,
8 but most individuals would undertake additional
9 specialties training in that topic, and
10 individuals who take it very seriously as a
11 major part of their practice would also probably
12 write the testamur examination as to specialty
13 in that area.
14 Q. Do you know Dr. Robert Rhodes?
15 Does that name sound familiar to you?
16 A. Repeat the name.
17 Q. Robert Rhodes, R-h-o-d-e-s?
18 A. I do not, no.
19 Q. If you, Dr. Benditt, or anyone else
20 doing similar work that you do wants to go and
21 get Board certified in cardiac pacing, is that
22 possible?
23 A. Not currently, no. Just to
24 continue that on, one can get a testamur of
25 special competency, which is the current

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Page 53

1 equivalent of the certification process. There
2 is discussion, however, about expanding it to
3 incorporate a true certification through one of
4 the major pacing organizations, but that has not
5 come to pass yet.
6 Q. Explain to me, Dr. Benditt, just
7 for my understanding of this area that you are
8 working in, why is it controversial? You used
9 the word controversial. Why is that?
10 A. There are a lot of individuals who
11 have been practicing in the field of pacing and
12 related sciences without any particular
13 specialty documentation for many years. Some of
14 those people are doing a fine job, and others
15 may not be doing such a fine job. The principal
16 reason to stop a certification process is to try
17 and establish some ground rules as to what the
18 training and experience ought to be, and attempt
19 to try and provide a level of quality service
20 that's fairly standard across the country.
21 This was the original goal of the
22 testamur examination, which many individuals
23 have taken and passed. But, there is a large
24 number of individuals who have been resistant to
25 that and who feel that another certification

Page 54

1 would infringe upon their livelihood, and there
2 are both political and legal issues that relate
3 to that kind of certification process.
4 Q. This NASPE, certificate of special
5 competency in cardiac pacing, what is NASPE?
6 A. It's the North American Society of
7 Pacing and Electrophysiology, which is the North
8 American professional organization which
9 encompasses the specialists in pacing,
10 arrhythmia work, and related sciences, basic
11 sciences included, and it's through that
12 organization that the examination is provided,
13 and it's that organization that would be the
14 body that would ultimately take on the
15 credentialing issue as well. Incidentally, it's
16 become an international body despite its name.
17 Q. Is this an independent
18 organization? It's not a government?
19 A. That's correct, it's an independent
20 organization.
21 Q. On your CV you list some
22 professional societies. You list that you're
23 member of the American Heart Association,
24 affiliate fellow; is that correct?
25 A. That's correct.

Page 55

1 Q. What is the position of the
2 American Heart Association on the causation
3 between smoking and various forms of
4 cardiovascular disease?
5 A. Their published position, as I
6 recollect it, and I don't have the brochures in
7 front of me, that smoking is an important risk
8 factor, and I think they might have even said
9 it's a cause of various forms of cardiovascular
10 disease.
11 Q. If I represent to you that the
12 American Heart Association from my examination
13 has publicly pronounced that it believes it is a
14 cause of cardiovascular disease, do you have any
15 reason to doubt what I'm telling you?
16 MR. CORNFELD: Object to the form
17 of the question and object to the repetitious
18 nature of the question, since he just said they
19 may have taken that position.
20 BY MR. MIKHAIL:
21 Q. Do you know for sure one way or the
22 other?
23 A. I don't have any reason to doubt
24 your statement. I don't have in front of me the
25 brochures that would confirm that in my mind,

Page 56

1 though. Specifically the cause issue.
2 Q. What about the Royal College
3 Physicians of Canada? Do you know what their
4 position is on the causation issue?
5 A. To my knowledge, they haven't
6 provided a statement in this regard.
7 Q. What about the electrophysiological
8 society, or would it even take a position on
9 something like that?
10 A. No position to my knowledge on this
11 topic.
12 Q. What about the American College of
13 Cardiology?
14 A. American College of Cardiology
15 position, to my understanding, is very similar
16 to the American Heart Association, but is a
17 little more scientifically based organization,
18 and I believe considers smoking to be a risk
19 factor.
20 Q. You say you believe it considers
21 smoking to be a risk factor. Do you know if the
22 American College of Cardiology considers smoking
23 to be a cause of various forms of cardiovascular
24 disease?
25 A. I have not seen them write that

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Page 57

1 specifically. It may be similar somewhere in
2 their literature that I haven't seen in the
3 materials that I've look at over the years. I
4 have generally seen them write about risk
5 factors as opposed to cause.
6 Q. But, today, you're not prepared to
7 tell me what their position is? I'm talking
8 about the American College of Cardiology.
9 A. I'm prepared to tell you that they
10 know smoking to be a risk factor.
11 Q. I understand. I'm talking about
12 whether they have a position that it is a
13 cause.
14 A. Can't answer that question.
15 Q. What about the Central Society for
16 Clinical Research?
17 A. To my knowledge, this is a purely
18 research society, it has no public statements in
19 regard to policy issues such as that.
20 Q. What about the North American
21 Society for Pacing and Electrophysiology?
22 A. No policy statement related to
23 smoking, to my knowledge.
24 Q. And what about the American Society
25 for Clinical Investigation?

Page 58

1 A. Another very basic research
2 organization, and I'm not aware of any policy
3 and statement in this related to smoking.
4 Q. Do you know what the American
5 Medical Association's view is to the causation
6 issue between smoking and cardiovascular
7 disease?
8 A. I do not.
9 Q. Do you know what the Surgeon
10 General's view is or conclusion as to the
11 causation issue between smoking and
12 cardiovascular disease?
13 A. The Surgeon General's view as
14 stated in the Surgeon General report has evolved
15 over many years, and I think current, I can't
16 say the most recent report, says cause. I've
17 seen in some reports they have talked both of
18 risk factors and have suggested that it's a
19 cause.
20 Q. Do you know what the 1983 Surgeon
21 General's report on cardiovascular disease
22 concludes on the issue of causation between
23 smoking and cardiovascular disease?
24 A. I would have to look at that report
25 again to be absolutely certain. My recollection

Page 59

1 is that they talk both of risk factors and of
2 cause.
3 Q. If the Surgeon General in the 1983
4 report concluded that smoking is a cause of
5 cardiovascular disease, would that view be
6 opposite of the view that you hold?
7 A. Yes, it would.
8 Q. And if the Surgeon General's view
9 currently is the same as it was in the 1983
10 cardiovascular disease report, that smoking is a
11 cause of cardiovascular disease, would that also
12 be opposite of your view today?
13 MR. CORNFELD: Object to the form
14 of the question, and specifically the term
15 opposite, which I assume you mean different, but
16 it's unclear.
17 BY MR. MIKHAIL:
18 Q. You may answer.
19 A. Yes, it would not be my view.
20 Q. Dr. Benditt, you are on a few, a
21 number of editorial boards, according to your
22 CV. I'm looking at the old one. Let me make
23 sure I get the right one. You have listed in
24 Benditt 1 the American Journal of Cardiology.
25 Do you see that?

Page 60

1 A. Yes, I have.
2 Q. That's on Benditt 1, I believe it's
3 Exhibit 1.
4 A. Yes.
5 Q. Do you know what the American
6 Journal of Cardiology editorial board position
7 is, if any, on the causation issue between
8 smoking and cardiovascular disease?
9 A. There's no position, to my
10 knowledge.
11 Q. What about the Journal of
12 Cardiovascular Electrophysiology?
13 A. No position.
14 Q. What about the Journal of
15 Interventional Cardioelectrophysiology?
16 A. No position.
17 Q. Have you read the 1983 Surgeon
18 General's report or any portions of it on
19 cardiovascular disease?
20 A. Indeed. I've read it all.
21 Q. You read the whole thing?
22 A. Correct, on cardiovascular disease.
23 Q. Do you remember when you read it?
24 A. I read it several times, actually.
25 Starting as far back as 1995, and I've read it

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at least two or three times since then.
Q. Are you familiar with the process that was undertaken to put together the 1983 Surgeon General's report on cardiovascular disease?
A. No.
Q. I'm going to read to you a portion of the introduction of the 1983 Surgeon General's report on cardiovascular disease that discusses what the contents of the report is. It's just a long sentence or two. I'll read them slowly. Rick, you're welcome to come and stand behind my shoulder. I don't have copies of it. I don't want to enter it as an exhibit. It reads, "The content of the report is the work of numerous scientists and experts within the Department of Health and Human Services as well as from outside the organization. Individual manuscripts were written by experts nationally and internationally recognized for their scientific contributions to the understanding of cardiovascular diseases. That is, manuscripts were reviewed individually by other experts within and outside the U.S. Public Health Service, and the entire report was reviewed by a

broad based panel of distinguished cardiovascular scientists."
MR. CORNFELD: Charles, can you tell us what page that is in the report?
MR. MIKHAIL: Page 3 of the 1983 Surgeon General's report on cardiovascular disease, the paragraph, actually right after the topic introduction, it says organization and development of the 1983 report.
MR. CORNFELD: Okay.
BY MR. MIKHAIL:
Q. Did you understand what I just read?
A. Yes, and to the extent, if that's the process, I understood that.
Q. Were you involved in any fashion, Dr. Benditt, in the process that culminated in the publication of the 1983 Surgeon General's report on cardiovascular disease?
A. No.
Q. You did not review any manuscript?
A. I think I can say pretty confidently, no.
Q. You were not. Have you been involved in the process, similar to what I've

just described by reading that report, of any Surgeon General's report?
A. No, I have not.
Q. Have you ever been asked to be involved?
A. No, I have not.
Q. Have you ever volunteered or tried to be involved and were turned down?
A. No.
Q. I'm going to go back to your CV, Benditt 1, and it lists some manuscript reviews. I take it, correct me if I'm mistaken, Dr. Benditt, I take that to mean you were a peer reviewer of manuscripts that other experts submitted for publication in those journals; is that correct?
A. That's correct.
Q. Circulation is one of them?
A. Correct.
Q. Do you know what the position is of Circulation, I guess Journal, on the issue of causation between smoking and cardiovascular disease?
A. To my understanding, Circulation does not have a position in this regard.

Circulation, as you're aware, is a publication of the American Heart Association, and from time to time, publishes statements and opinions and whatnot from the American Heart Association.
Q. What about Circulation Research?
A. Also a publication of the American Heart Association, and generally a basic research paper would be published in that journal, and to my knowledge, they don't publish policy statements of the kind that we're discussing.
Q. And same question about the American Journal of Cardiology?
A. The remainder of the journals listed here, American Journal of Cardiology, Journal of Cardiovascular Electrophysiology PACE and Journal of Postgraduate Medicine are independent journals and have no specific statement, to my knowledge, related to the smoking, cardiovascular disease issue.
Q. The causation issue specifically?
A. Specifically, yes.
Q. Dr. Benditt, I don't want you, and I'm not trying in any way to get you to reveal any proprietary information, and I hope Mr.

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Page 65

1 Cornfeld will respect that. I simply want to
2 ask you on these consultancies where you are on
3 the medical advisory board to some
4 pharmaceutical companies, 3M Pharmaceuticals,
5 Medtronic, and is it Angeion?
6 A. Correct.
7 Q. Is that how you pronounce that?
8 Can you just tell me generally without revealing
9 any proprietary information, what general areas
10 are you consulting on?
11 A. Yes. In terms of the
12 pharmaceutical industry, 3M specifically, it
13 relates strictly to anti-arrhythmic drugs. It
14 has nothing to do with smoking or cardiovascular
15 disease. With respect to both Medtronic and
16 Angeion, it relates to implantable devices,
17 consulting in terms of features that might be
18 desirable, technical issues that might relate to
19 implantation of pacemakers and implantable
20 defibrillators. Again, has nothing to do with
21 the issue we're discussing.
22 Q. Is it product development
23 basically?
24 A. Some of it is product development,
25 some of it is development of clinical research

Page 66

1 tools to assess products that have been
2 developed, and some of it relates to a basic
3 think tanking, if you will, as to new products
4 and new features that might be desirable in new
5 products.
6 Q. But, it has nothing to do with the
7 issue we're talking about today, that is smoking
8 causation of smoking and cardiovascular disease?
9 A. Yes, you can be assured it has
10 nothing to do with it.
11 Q. Do you perform angioplasty in your
12 specialty?
13 A. No, I have colleagues who do
14 thousands of them, and I refer my patients to
15 them.
16 Q. If you wanted to, would you be
17 allowed to in your specialty?
18 A. I could, but I've never applied for
19 that specific privilege in any of the hospitals
20 I've worked.
21 Q. Are you engaged in diagnosis of
22 patients, that is, to diagnose whether or not
23 they are suffering from a cardiovascular
24 disease?
25 A. That's correct, yes, I do that.

Page 67

1 Q. You do that, okay. And if any of
2 those patients require intervention of some sort
3 or surgical invasive procedures, you refer them
4 to a cardiovascular surgeon or peripheral
5 vascular surgeon?
6 A. Yes, I think just to be more
7 specific, if they require diagnostic
8 intervention, they may require any of several
9 kinds of procedures, some of which I do, some of
10 which I don't do.
11 Q. You described some of the invasive
12 procedures you do, but other than those.
13 A. Correct, if they require any
14 surgical intervention apart from implantation of
15 the pacemaker and defibrillator, I would refer
16 them to a surgical colleague who specializes in
17 that area.
18 Q. Doctor, I've been a patient and I
19 come from a medical family, and I know that
20 patients often ask, Doc, what caused this
21 condition that I have. Do you have patients
22 asking you what caused my cardiovascular
23 disease? What caused my heart attack?
24 A. I do.
25 Q. Have you ever told a patient that

Page 68

1 smoking caused your heart attack?
2 A. I may have.
3 Q. Why did you do that?
4 A. There is a difference between
5 public education and scientific basis of our
6 knowledge. And essentially in forming the
7 public and in trying to motivate individual
8 patients to change behavior patterns, one does
9 make statements that may not be scientifically
10 very valid, but are at least well meaning and
11 heading in the right direction. And certainly
12 changes in behavioral patterns for individual
13 patients are difficult to achieve, and if one
14 waffles on one's advice, the odds of it being
15 accepted is rather poor.
16 So, one tends to be more dogmatic
17 in dealing with a clinical situation such as
18 you've painted than one would be in assessing
19 the literature and the true science behind that
20 statement.
21 Q. But, would your testimony be, Dr.
22 Benditt, that if the Surgeon General or the
23 American Heart Association or your colleagues
24 state or express the opinion, medical judgment,
25 that smoking causes, or is a cause of

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Page 69

1 cardiovascular disease, that they're being
2 unscientific?
3 A. If they express that cause without
4 framing it in a broader context, the answer
5 would be yes.
6 Q. In the patients that you have used
7 that term, cause, would you have also recorded
8 in their medical records that smoking caused
9 their particular form of cardiovascular disease?
10 A. No, I would not have.
11 Q. You don't recall any instance when
12 you used that terminology in your medical
13 records?
14 A. I'm almost positive that I've never
15 written that in the medical record anywhere at
16 any time.
17 Q. Mr. Benditt, in the books that you
18 have listed on your CV, let's do this, I keep
19 referring to this one, it's on page four of
20 Benditt 11. You have three listed here. And I
21 see all of them indicating that you were an
22 editor or one of the editors of the books,
23 correct?
24 A. That's correct.
25 Q. Am I to take that that you were not

Page 70

1 an author of any of the chapters of those books?
2 A. I authored chapters in each of
3 those books as well, yes.
4 Q. Did any of the chapters that you
5 authored in these three books listed under the
6 headline, "Books" on page four, have anything to
7 do with the issue of causation between smoking
8 and cardiovascular disease?
9 A. No, they don't.
10 Q. What about the patent? Does it
11 have anything to do with the causation issue?
12 A. No, it doesn't.
13 Q. I'm sure it didn't, but I just
14 wanted to ask. What about the peer reviewed
15 publications? I know there are a number of them
16 here. I mean, there are a vast number of
17 publications that you have to your credit. I
18 don't want to take too much time, but are you
19 able to glance at the list of peer reviewed
20 publications and tell me if any of the peer
21 reviewed publications that you have have to do
22 with the issue of causation between smoking and
23 cardiovascular disease?
24 A. None of these peer reviewed have
25 anything to do with that topic.

Page 71

1 Q. And several of them I see that you
2 are primary author on, correct?
3 A. That's right.
4 Q. And others you are either second,
5 third or fourth or fifth author of; is that
6 correct?
7 A. That's correct.
8 Q. The ones that you are not the
9 primary author on, could you tell me generally
10 what type of contribution you made as a
11 secondary author?
12 A. In general terms, supplying data.
13 For example, multi-center studies. Co-authoring
14 the manuscript in terms of either writing
15 passages or correcting the whole manuscript or
16 editing, I guess is a better term. Those would
17 be the principal functions that would be served
18 in co-author. On occasion, I'm the co-author
19 with one of our trainees, in which case, I
20 probably have a greater input in terms of
21 directing the way the manuscript is written and
22 the way it's edited.
23 Q. If you'll look, Dr. Whitsett, on
24 page 17 of Benditt 1. It lists the book
25 chapters and invited publications. Do you see

Page 72

1 that? If you will take a glance at the number
2 of, take however long you need to, of the list
3 of publications listed under this heading.
4 Could you tell me if any of them have to do with
5 the issue of causation or relationship between
6 smoking and cardiovascular disease?
7 A. No, they do not.
8 Q. What about the book reviews listed
9 on page 23?
10 A. No, it does not relate.
11 Q. What about any of the abstracts?
12 A. They do not relate directly to the
13 issue of causation. Could you mark this, Joan?
14 (Whereupon, Deposition Exhibit No.
15 4 was marked for identification and a copy is
16 attached and hereby made a part of this
17 deposition.)
18 BY MR. MIKHAIL:
19 Q. Dr. Benditt, I'm going to hand you
20 what we've marked as Benditt 4. Let me ask you
21 -- I'm sorry. What was your involvement in the
22 Minnesota case? Did you actually testify as an
23 expert in that trial?
24 A. No, I did not testify. The issue
25 was settled prior to my being called to testify.

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Page 73

1 Q. Did you give a deposition in that
2 case?
3 A. Yes, I did.
4 Q. And your recollection is that it
5 was settled before you were going to be called
6 to testify?
7 A. That's correct.
8 Q. Were you actually told that you
9 were going to be called to testify?
10 A. Actually, I was told about two
11 weeks before I was expecting to testify that
12 they were not going to call me.
13 Q. They, I'm assuming it's counsel for
14 the clients that you represent, but did they
15 tell you that you were not going to be called
16 because the case was settling or did they tell
17 you they just decided not to put you on?
18 MR. CORNFELD: Object to the form
19 of the question to the extent it referred to
20 clients that he represented.
21 MR. MIKHAIL: Whoever. Whoever
22 "they" is. My wife says that they know
23 everything.
24 MR. CORNFELD: That's true.
25 BY MR. MIKHAIL:

Page 74

1 Q. The "they" that we're talking about
2 --
3 MR. CORNFELD: Even though they're
4 often wrong.
5 BY MR. MIKHAIL:
6 Q. The they we're talking about that
7 you're talking about, did they actually tell you
8 you weren't being called because it was settling
9 or they just decided not to call you?
10 A. I was given no explanation.
11 Q. Okay. Do you know if any other
12 physicians were called to testify at the trial
13 on behalf of the defendants in the case?
14 A. I don't know specifically who was
15 called to testify on behalf of the defendants.
16 Q. I handed you Benditt 4. I believe
17 it's 4, just so the record will be clear. This
18 is a document provided us by Mr. Cornfeld as
19 required by the court order as to disclosure
20 material, and it's entitled, "Oklahoma Tobacco
21 Litigation, David G. Benditt M.D., Reliance
22 Material." Do you see that?
23 A. I do.
24 Q. Could you take a moment and look at
25 that document and tell me if the documents that

Page 75

1 are listed in Benditt 4 are in fact documents
2 upon which you are relying in giving your
3 testimony, your expert testimony in this case.
4 A. Yes, these are documents that I'm
5 relying on.
6 MR. CORNFELD: Charles, wasn't
7 there a later one?
8 A. There is one additional document by
9 Wilson in circulation.
10 BY MR. MIKHAIL:
11 Q. I'm getting at that. I didn't ask
12 you if this is all. I'm asking you if the
13 documents listed in Benditt 4 are in facts
14 documents on which you are relying.
15 A. Yes.
16 Q. Yesterday I was FAXed by the firm
17 of Ness, Motley a copy of an article by Wilson
18 and others, entitled, Prediction of Coronary
19 Heart Disease Using Risk Factor Categories."
20 I'm not going to mark this, but are you relying
21 on the article entitled, Prediction of Coronary
22 Heart Disease Using Risk Factor Categories by
23 Wilson and others for your testimony?
24 A. Yes, I am.
25 MR. CORNFELD: Charles, as far as

Page 76

1 Exhibit 4 is concerned, did we FAX a later
2 version of this with the 7 day disclosure
3 statement, or is this -- I just don't remember.
4 MR. MIKHAIL: This is the only
5 thing Ness, Motley provided me two days before
6 this deposition, I believe, and also they
7 provided me with a couple of other things that
8 you also provided them along with it. One
9 called Tobacco Experimental and Clinical
10 Studies, it's a 1961, looks like it might be a
11 chapter from a book and copy of it from 1968.
12 That's all that was provided to us.
13 MR. CORNFELD: I don't remember the
14 dates of when things were provided. I know we
15 provided the seven day disclosure.
16 MR. MIKHAIL: This was the seven
17 day disclosure. This is what was provided us
18 seven days prior to disclosure.
19 MR. CORNFELD: It shoes a FAX date
20 from my office of October 15, which was two
21 weeks ago. So, you know.
22 MR. MIKHAIL: That's the only thing
23 I was provided. I'll check and see. Are you
24 suggesting or saying that there may be a more
25 current version? I'm not questioning you, Rick,

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Page 77

1 honest, I really am not.
2 MR. CORNFELD: The answer is, I
3 don't know. I have with me the disclosure
4 statement that's got literature attached, and I
5 don't know if it's -- well, it's not --
6 MR. MIKHAIL: Do you have with you
7 a reliance material document that includes items
8 more than what I've handed you? More than
9 Benditt 4? Do you want to look at Benditt 4?
10 MR. CORNFELD: I don't know. What
11 I have is something called seven day disclosure
12 for David G. Benditt, M.D. that has, it's the
13 seven day disclosure.
14 MR. MIKHAIL: Yeah, I've got that.
15 MR. CORNFELD: It has a list of
16 literature under the heading, paragraph 6b, and
17 what I don't know is whether any of the
18 literature -- I just don't know off the top of
19 my head whether there's anything listed under
20 paragraph 6b that is not in what you just marked
21 as Exhibit 4.
22 MR. MIKHAIL: I think I understand
23 what you're saying. What you're saying is
24 Benditt 4 includes a document you provided
25 Plaintiff's counsel on October 16. In the seven

Page 78

1 days disclosure, which I'm going to have marked
2 in a few moments, that actually has a narrative
3 of his opinions. At the end of the narrative it
4 lists documents that he's going to rely on. You
5 don't know if the lists are all inclusive or the
6 same?
7 MR. CORNFELD: Whether they're
8 identical or what, actually, off the top of my
9 head.
10 MR. MIKHAIL: That's fair enough,
11 that's fine.
12 BY MR. MIKHAIL:
13 Q. Let's talk about Benditt 4, I'll
14 ask if you'll take a look at it and tell me if
15 these are articles or documents upon which you
16 rely in giving your testimony.
17 A. Yes, they are.
18 Q. Are there any documents on Benditt
19 4 that you either authored as a primary author
20 or secondary author?
21 A. No, there are not.
22 Q. Did you select these documents, or
23 did counsel for any of the tobacco manufacturers
24 or the tobacco institute supply you with either
25 this list and/or the documents?

Page 79

1 A. I identified these documents.
2 Q. What, Dr. Benditt, is the -- well,
3 is there a consensus opinion in the documents
4 upon which you are going to rely, which are
5 reflected in Exhibit 4? Is there a consensus in
6 these materials on the issue of causation
7 between smoking and cardiovascular disease?
8 A. Yes.
9 Q. And what is that consensus?
10 A. That smoking is a known risk factor
11 for cardiovascular disease, but is not a proven
12 cause.
13 Q. So, you are representing to me that
14 the documents on Benditt 4, the consensus is
15 that it is not a cause of cardiovascular
16 disease?
17 A. But it is a risk factor, that's
18 correct.
19 Q. But it is a risk factor, okay.
20 When you were asked to give testimony in this
21 case on the issue of causation, and in
22 preparation for the testimony, did you go and do
23 a search to pull these articles? How did you go
24 about identifying these particular articles in
25 Benditt 4?

Page 80

1 A. Basically that way. A search on
2 articles related to cardiovascular disease,
3 smoking, risk factors, etc., and some of these
4 articles were already in my files, and others I
5 had to get from the library.
6 Q. What exactly, what were you
7 searching for? Was there any particular key
8 that you were using to look for articles?
9 A. No. I basically took anything and
10 everything that I could find that even remotely
11 suggested that had any relationship to smoking,
12 tobacco use, risk factors, and I was available
13 to read anything I could get my hands on that
14 seemed pertinent.
15 Q. Are there any of these that
16 consider smoking a cause of cardiovascular
17 disease?
18 A. I'm sure there are.
19 Q. But, you're saying that the
20 consensus of the documents upon which you're
21 relying on in Benditt 4 are that it is a risk
22 factor but not a cause?
23 A. Correct.
24 Q. What, if any, criteria or standard
25 did you use in selecting the documents reflected

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Page 81

1 in Benditt 4 as opposed to the entire body of
2 literature that you searched and found?
3 A. Basically, I just took anything
4 that related to smoking, and many of these
5 articles contain references, divisional
6 references to the topic, and I felt that these
7 articles were quite representative of the body
8 of knowledge that I surveyed, and if necessary,
9 we could go into the specific references
10 entailed in each one of these, including one
11 that you have, which is a survey of the world's
12 literature, which has hundreds of references.
13 So, this body of reliance material
14 also accesses for me a much faster underlying
15 body of material, if you should want to go into
16 it.
17 Q. You weren't looking for articles
18 that said it was a risk factor and not a cause
19 particularly?
20 A. No, I had the radar screen wide
21 open, and the consensus based on my survey of
22 this literature is what I proposed.
23 Q. Do you know why the Surgeon General
24 in review of literature for the Surgeon
25 General's report comes to a different

Page 82

1 conclusion, and that is that the consensus or
2 body of literature is overwhelming that smoking
3 is a cause of cardiovascular disease?
4 MR. CORNFELD: Object, lack of
5 foundation. Object to the form of the
6 question.
7 BY MR. MIKHAIL:
8 Q. You may answer that.
9 A. Frankly, I'm not sure the Surgeon
10 General says that specifically, and I think we
11 should review the Surgeon's General's report and
12 find out if he quotes it that way. My review of
13 the Surgeon General's reports suggest to me that
14 they actually couch this much more carefully
15 than that, and that while they do mention cause
16 from time to time, most of the evidence that
17 they present is in terms of risk factors.
18 Q. Okay, Dr. Benditt, we'll get to
19 that a little bit later as to what the Surgeon
20 General states, but in 1983, as early as the
21 1983 Surgeon General's report, one of the
22 conclusions, and I'll read it to you, is
23 "Cigarette smoking is a major cause of coronary
24 heart disease in the U.S. for both men and
25 women." Do you know why the Surgeon General in

Page 83

1 1983 reached the conclusion from the survey of
2 the literature and the body of publications
3 available on the topic, reached the conclusion
4 that it's a major cause, when your review in
5 preparation for this testimony found a different
6 conclusion, and that is the consensus of the
7 literature to be otherwise?
8 MR. CORNFELD: Object, lack of
9 foundation and object to the form of the
10 question.
11 BY MR. MIKHAIL:
12 Q. You may answer. Do you know that?
13 A. I can only speculate as to what was
14 in the Surgeon General's mind. A number of
15 speculations might include the possibility that
16 they didn't seriously want to study the
17 literature and report what the literature really
18 stated, or likely I think what they were trying
19 to do was much analogous to what your example of
20 my talking to the patient in the clinic is all
21 about. You have to be doing mathematics to get
22 people's attention, and if you want to try to
23 make a point, if you waffle it won't be
24 accepted.
25 In fact, that statement that you

Page 84

1 just read is not supported by the evidence that
2 they provide in the reports. If one carefully
3 reads the evidence that they provide, and even
4 when they state the evidence in the scientific,
5 more scientific segments of the report, rather
6 than just the conclusions where they're trying
7 to get some public attention, you find that they
8 tend to couch it much more carefully.
9 THE VIDEOGRAPHER: Going off the
10 video record. The time is approximately 11:28
11 a.m. Elapsed time is 1 hour, 48 minutes and 51
12 seconds.
13 (WHEREUPON A SHORT RECESS WAS HAD)
14 (Whereupon, Deposition Exhibit No.
15 5 was marked for identification and a copy is
16 attached and hereby made a part of this
17 deposition.)
18 THE VIDEOGRAPHER: We're back on
19 the video record. The time is now approximately
20 11:43 a.m. Elapsed time is 2 hours, 3 minutes
21 and 32 seconds.
22 BY MR. MIKHAIL:
23 Q. Dr. Benditt, let's go back to
24 something we talked about before the break. You
25 mentioned in advising patients or talking to

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Page 85

1 patients that you have used the word "cause."
2 You said that you, you know, you want to be
3 dogmatic so that they change their behavior or
4 alter their ways, but if smoking didn't cause
5 harm to those patients, why be so dogmatic?
6 MR. CORNFELD: Let me make an
7 objection because I think what Dr. Benditt said
8 is he wouldn't be surprised if he had used the
9 word "cause" with patients. I don't know if he
10 actually said affirmatively he had done so.
11 BY MR. MIKHAIL:
12 Q. You may answer.
13 A. I think it's very clear literature
14 that smoking is one of the risk factors for
15 heart disease, and that in patients who have
16 recognized heart disease, or who are at high
17 risk because of family history or things of that
18 nature, or who have lots of other risk factors
19 that perhaps we can't so readily deal with, that
20 it seems reasonable to try and modify the risk
21 factors that we can deal with. Consequently, I
22 would try to do that, as I think most
23 cardiologist and physicians would try to do.
24 And in the sense that you sometimes
25 need to use a hammer to get people's attention,

Page 86

1 we make statements that are dogmatic but not
2 scientifically critically supported. And I
3 think the American Heart Association and the
4 Surgeon General can be said to have done the
5 same thing.
6 Q. But, why alarm the patient? Why
7 scare the patient with such dogmatic advice,
8 that it causes your heart attack or causes harm
9 to you if that's unscientific?
10 A. Well, I think the scientific part
11 is that it is a risk factor for the
12 manifestations of heart disease. That's not
13 unscientific. What the important point is that
14 we don't scare the patient, we educate the
15 patients, and at least we attempt to, and we
16 have to recognize that in educating people, we
17 use information that's gleaned from many
18 sources, and we don't necessarily critically
19 review all those sources, except when
20 specifically a situation comes up that we want
21 to get very detailed insight into it. And so
22 the education process isn't the scaring process,
23 it's a process of trying to develop insight into
24 how a problem might be made worse or might be
25 made better.

Page 87

1 Q. Your testimony is that when you or
2 any other cardiologist treating a patient tells
3 the patient that smoking caused their heart
4 attack or caused coronary artery disease, that
5 that is unscientific information being given to
6 the patient?
7 A. The point I'm trying to make is
8 that it's unscientific to attribute to smoking
9 that it was the cause of the problem in the
10 sense there are risk factors associated for
11 manifestations of heart disease. Most patients,
12 if not all, have many, multiple risk factors,
13 and often risk factors that we don't even know
14 about, and that one has to, if one were to be
15 truly scientific, point that out. However, as
16 you well know, probably from your own personal
17 experience, if one started to go through a
18 monologue on risk factors for individual
19 patients, I think we would probably not get
20 their attention.
21 Q. Dr. Benditt, if a cardiologist
22 diagnosing and treating a patient looks at the
23 medical history of the patient, examines the
24 patient, looks at the family history and the
25 habits and activities which the patient engages,

Page 88

1 smoking, the patient has high blood pressure,
2 they have a bad diet, all of the evidence, then
3 compares it with or examines it, weighs it in
4 light of epidemiological evidence, and from the
5 totality of that information available to that
6 cardiologist, if that cardiologist were to reach
7 a conclusion and opinion that smoking caused
8 that patient's heart attack, is that
9 unscientific?
10 A. Yes.
11 Q. For the cardiologist to do that?
12 A. Yes.
13 Q. Even looking at it from the
14 totality of the evidence, both epidemiological,
15 pathological, laboratory and clinical
16 observations of the patients, your testimony is
17 that that conclusion by the cardiologist is
18 unscientific?
19 A. That's my opinion, yes.
20 Q. Wouldn't you say, however, that it
21 is nevertheless a medical judgment that that
22 cardiologist reached, whether you would
23 characterize it as unscientific or not, isn't it
24 a medical judgment that that cardiologist
25 reached from looking at the totality of the

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Page 89

1 evidence?
2 A. Yes, people make judgements about
3 evidence all the time. Not necessarily correct,
4 but they make judgements.
5 Q. Do you discount the possibility
6 that from looking at the totality of the
7 evidence, that cardiologist making a judgment,
8 medical judgment on causation, do you fault that
9 physician from a scientific standpoint for doing
10 that?
11 A. I don't fault the physician. I'm
12 just pointing out that if you provided the
13 physician the detailed insight into what the
14 epidemiologic studies really said and what the
15 pathologic studies really provided and what the
16 relationship between the risk factor and the
17 onset of the manifestation of heart disease
18 truly was, those physicians would probably
19 change their scientific thought about the
20 problem, but they might still use the same
21 statements to the patient to gather the
22 patient's attention.
23 Q. But, when a cardiologist does that,
24 gives the opinion that smoking caused the
25 particular cardiovascular disease in a patient

Page 90

1 after looking at the individual circumstances of
2 that patient, epidemiology, laboratory results,
3 I'm talking about general results from
4 laboratory experiences, that the medical
5 judgment reached by that physician as to
6 causation is not scientific?
7 A. Well, let me phrase it this way.
8 We know at least from a variety of different
9 sources how to come to a relationship that is a
10 causation relationship, and I can guarantee you
11 that in any individual patient, those
12 relationships cannot be established to that
13 level of scientific certainty, so it is
14 unscientific.
15 Q. So, that judgment as to causation
16 by that cardiologist under the circumstances I
17 described in your opinion would be
18 unscientific?
19 MR. CORNFELD: Object to the
20 repetitious nature of the question.
21 A. That's what I said.
22 BY MR. MIKHAIL:
23 Q. Dr. Benditt, can an opinion of a
24 cardiologist, diagnosing and treating a patient,
25 be scientific, in your opinion, as to the

Page 91

1 causation issue only if the mechanism is known
2 or discovered for cardiovascular disease as it
3 relates to smoking on a molecular or cellular
4 level? Is a conclusion as to causation only
5 scientific if the mechanism is known?
6 MR. CORNFELD: Object to the form
7 of the question.
8 BY MR. MIKHAIL:
9 Q. You may answer.
10 A. I would say, you phrased the
11 question as only scientific. I'd say it could
12 be scientific if the mechanism is known or would
13 be scientific if the mechanism is known. But,
14 that's not a necessary and essential feature to
15 relate causation.
16 Q. So, discovering or knowing the
17 mechanism for what in smoke could cause, have a
18 causal relationship, causal effect relationship
19 with cardiovascular disease is not a necessary
20 element in being able to reach a conclusion as
21 to causation that would be scientific?
22 A. That's correct.
23 Q. Isn't that what the generally
24 accepted view among cardiologists is about the
25 causal relationship between smoking and

Page 92

1 cardiovascular disease?
2 MR. CORNFELD: Object to the form
3 of the question.
4 BY MR. MIKHAIL:
5 Q. They don't know the mechanism, but
6 they're reaching a medical judgment, aren't
7 they?
8 A. I can't speak for --
9 MR. CORNFELD: Excuse me, I'd like
10 to lodge another objection to the form of the
11 question, and that is that it is unclear whether
12 you're talking about an opinion by a
13 cardiologist that smoking in general can cause
14 heart disease or an opinion by a cardiologist,
15 which is what I think you started to ask, but
16 now it's a different question, an opinion by a
17 cardiologist that a particular patient's heart
18 disease was caused by smoking.
19 MR. MIKHAIL: Oklahoma procedure
20 and rules do not allow this type of objection,
21 speaking objection. You are permitted and you
22 all have hounded us with a hammer to our head,
23 to object to form and move on, but you cannot --
24 MR. CORNFELD: I have not hounded
25 anybody.

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Page 93

1 MR. MIKHAIL: I'm not saying you
2 did, your co-counsel. I'm just saying, these
3 type of speaking objections are not permitted,
4 and the judge has been very strict about it and
5 has cautioned both sides about it.
6 MR. CORNFELD: I have made my
7 objection. We can argue about it all afternoon,
8 but I have made my objection.
9 MR. MIKHAIL: I don't want to do
10 that. You can object to form.
11 MR. CORNFELD: Doctor, if you
12 understand the question, you can answer.
13 MR. MIKHAIL: Can you reread the
14 question?
15 ....Whereupon, the following
16 question was read back by
17 the Court Reporter: "Q. They
18 don't know the mechanism, but they're reaching a
19 medical judgment, aren't they?"
20 A. They don't know the mechanism, but
21 they are reaching a medical judgment. That is
22 correct.
23 BY MR. MIKHAIL:
24 Q. And I understood you to also say,
25 just a moment ago, and correct me if I'm

Page 94

1 mistaken, that it would not necessarily be
2 unscientific to reach that medical judgment,
3 even without knowing the mechanism?
4 A. That's correct, I said that.
5 Q. We have marked another exhibit,
6 Benditt 5, and that's the seven day disclosure
7 that you sent us Rick. Just very quickly some
8 housekeeping matter to take care of. Attached
9 to Benditt 5, if you'll turn a few pages, Dr.
10 Benditt, to, I think it's page seven, it has a
11 list from page seven to the end, to page 11. It
12 has a list of various documents upon which you
13 will rely in giving your testimony. Do you see
14 that?
15 A. Yes, I do.
16 Q. Are these in fact documents that
17 you will be relying on in giving your opinion in
18 this case?
19 A. I will rely on these, yes.
20 Q. In addition -- let me ask you
21 this. Did you author or were you a secondary
22 author on any of these documents?
23 A. No, I was not.
24 Q. On Benditt 5?
25 A. I was not a secondary or primary

Page 95

1 author on any of these.
2 Q. We were furnished with the Wilson
3 article. I'm not going to attach this as an
4 exhibit, but the Wilson article yesterday that
5 you made reference to. You may look at it if
6 you'd like, but I'm just going to ask you a
7 quick question about this.
8 MR. CORNFELD: Just so the record
9 is clear, Charles, could you read the times?
10 MR. MIKHAIL: I did that earlier,
11 I'll do it again. An article titled,
12 "Prediction of Coronary Heart Disease Using
13 Risk Factor Categories," by Peter Wilson and
14 others. For what specific proposition are you
15 relying on this article on? I read it this
16 morning early with a cup of coffee in my hotel
17 room, and I want you to tell me what the
18 proposition is, not of the article, but what the
19 proposition is that you believe this article
20 supports.
21 A. This particular article, as does
22 several others that relate to the Framingham
23 study deals with, in my view, deals with the
24 issue of the dose responsiveness issue, smoking
25 versus its purported causation of cardiovascular

Page 96

1 disease, and that is basically in this article
2 refuted.
3 Q. And that's the proposition that
4 you're using this article for?
5 A. That was the principal reason to
6 present it, but obviously it follows the law and
7 history of the Framingham study, and it just so
8 happens it was published very recently, so it
9 seemed pertinent to add on.
10 Q. In Benditt 5, the seven day
11 disclosure and the opinions that you give, look
12 on page 3 under coronary artery disease. The
13 second paragraph. When we say coronary artery
14 disease, we are referring to the same thing as
15 coronary heart disease, aren't we?
16 A. I think in practical usage that's
17 true, yes.
18 Q. Do you see that paragraph where it
19 says, "Coronary artery disease is a complex
20 multifactorial condition, risk factors
21 associated with the development of coronary
22 artery disease include age, male gender, genetic
23 predisposition, hypercholesterolemia, elevated
24 blood lipids, smoking, diabetes, mellitus,
25 sedentary life-style, hypertension, lack of

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Page 97

1 exercise, type A personality and race." Do you
2 see that?
3 A. Yes, I do.
4 Q. Isn't it true, Dr. Benditt, that
5 notwithstanding your listing these various risk
6 factors, which are not all inclusive, but these
7 are risk factors, that the primary risk factors
8 are smoking, or classic risk factors for CHD are
9 smoking, hypertension and cholesterol?
10 A. Not quite complete. Diabetes is
11 very important.
12 Q. Aside from diabetes. Let's put
13 diabetes aside. Because that is a rather unique
14 case with people who are diabetic. Aside from
15 diabetes, of the various risk factors you list
16 here and the various ones commonly mentioned,
17 the classic ones are cholesterol level, smoking
18 and hypertension, isn't that right?
19 MR. CORNFELD: Object to the form
20 of the question.
21 A. No, that's not quite accurate, and
22 I don't mean to give you a hard time over this,
23 but I think that it's important to divide the
24 risk factors into those that are reversible,
25 purportedly.

Page 98

1 BY MR. MIKHAIL:
2 Q. Modifiable?
3 A. Modifiable, and those that are not,
4 and I think you've listed the most important of
5 the ones that seem to be modifiable, but not
6 necessarily the most important risk factors.
7 Q. But, they are important modifiable?
8 A. Yes.
9 Q. The reason I just asked you that is
10 because the article upon which you rely, Wilson,
11 if you'll take a look at that. On the right
12 hand column?
13 A. Which page are you looking at?
14 Q. On the first page on the right hand
15 column where it says, the second line at the end
16 of the line where it starts with the word
17 "This." Do you see that? Not in the paragraph
18 that says "methods." It's the paragraph above
19 the one that says "methods." On the second
20 line, it says, it's talking about this study
21 that you are relying on. It says, "This
22 approach emphasizes the established, powerful,
23 independent and biologically important factors.
24 Family history for heart disease, physical
25 activity and obesity are not included because

Page 99

1 these factors work to a large extent through the
2 major risk factors, and their unique
3 contribution to CHD condition can be difficult
4 to quantify."
5 I believe that the ones listed, the
6 ones listed here that I just read are considered
7 to be if I understand it correctly, and you tell
8 me, are less established powerful independent
9 and biologically important factors?
10 A. Are you referring to family
11 history, physical activity --
12 Q. Obesity, yes.
13 MR. CORNFELD: Let me object to you
14 not letting Dr. Benditt look at this entire
15 article. This is just a section in the
16 introduction.
17 BY MR. MIKHAIL:
18 Q. We don't have to do that. Just
19 tell me --
20 A. I disagree with the concept that
21 family history is not considered to be
22 important. Family history is, I think,
23 generally considered to be the single most
24 important with the possible exception of male
25 gender.

Page 100

1 MR. MIKHAIL: I think we just have
2 less than five minutes of the video. Let me get
3 a question in. Could you give me a victory sign
4 when there are two minutes?
5 BY MR. MIKHAIL:
6 Q. Are you familiar with Harrison's
7 Principals of Internal Medicine?
8 A. Yes, I am.
9 Q. I was looking through that book in
10 connection with other medical testimony that
11 I've been working on, and there's a section on
12 cardiovascular disease, and it says, "Cigarette
13 smoking is a major cause of coronary heart
14 disease, and premature CHD is one of its most
15 important medical consequences." I take it you
16 disagree with the first part of that sentence
17 that says, "Cigarette smoking is a major cause
18 of coronary heart disease," it's on page 2434 of
19 Harrison's Principles of Internal Medicine.
20 MR. CORNFELD: I object to asking
21 the witness to comment on what's one half of a
22 sentence taken out of a massive book of
23 Harrison's without showing him everything and
24 just reading it to him.
25 MR. MIKHAIL: You've done that at

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Page 101

1 every deposition I've attended.
2 MR. CORNFELD: I've never done
3 that.
4 BY MR. MIKHAIL:
5 Q. Did you disagree with that
6 statement in Harrison's? You're welcome to look
7 at it.
8 A. Let me please look at it.
9 THE VIDEOGRAPHER: Going off the
10 video record. The time is now approximately
11 12:03 p.m. Elapsed time is 2 hours, 24 minutes
12 and 19 seconds. This is the end of tape number
13 1.
14 (WHEREUPON A SHORT RECESS WAS HAD)
15 THE VIDEOGRAPHER: We're back on
16 the video record. The time is now approximately
17 12:05 p.m. Elapsed time is 2 hours, 26 minutes
18 and 11 seconds.
19 BY MR. MIKHAIL:
20 Q. Are you able to answer the question
21 I asked?
22 A. Yes. This is a rather interesting
23 quotation that you've pulled out from a series
24 of four paragraphs, I guess three paragraphs, in
25 which at least five of the six times that

Page 102

1 cigarettes are mentioned more or less, they use
2 the term risk factor, and only once do they use
3 the word cause.
4 The fact that they use the word
5 major cause, just to focus on the specifics of
6 your question, indicates that this was not very
7 carefully written because it's not supported by
8 the scientific evidence, whereas the remainder
9 three paragraphs are much more carefully
10 written, or at least the terminology is more
11 carefully used in terms of risk factor, and we
12 could then talk about defining what major is and
13 what cause is. I'm happy to do either if you
14 want to get into that.
15 Q. Really my question was, and feel
16 free to explain as you wish, I'm not trying to
17 cut you off, my question was, I read you that
18 first sentence, that it is a major cause of
19 coronary heart disease. I'm asking if you agree
20 with that statement or not.
21 MR. CORNFELD: Object to the
22 repetitious nature of question.
23 A. Definitely not.
24 BY MR. MIKHAIL:
25 Q. Dr. Benditt, just approximately how

Page 103

1 much, if you can give me even a percentage of
2 your income each year is from testifying as an
3 expert witness? Let's start with this year,
4 1998.
5 A. Five percent.
6 Q. In other years is it about the
7 same?
8 A. Usually less than that.
9 Q. And if I understood your testimony
10 earlier, you testified for both plaintiffs and
11 defendants, correct?
12 A. I have, yes.
13 Q. If you will look at, I believe it
14 is Benditt 5. I believe it's the list of -- is
15 that it? The list of opinions, yeah, the
16 disclosure, seven day disclosure. If you'll
17 turn to page 11.
18 MR. MIKHAIL: You have a copy of
19 that, don't you, Rick?
20 MR. CORNFELD: Yes. Exhibit 5,
21 right?
22 MR. MIKHAIL: Exhibit 5, yeah.
23 BY MR. MIKHAIL:
24 Q. Page 11, under paragraph 6d as in
25 dog. Do you see that?

Page 104

1 A. I do.
2 Q. I think you list to the best of
3 your recollection different cases that you have
4 been involved in?
5 A. I have.
6 Q. I mean, as an expert witness?
7 A. Yes.
8 Q. I see Humphrey versus Phillip
9 Morris. That is the Minnesota tobacco case.
10 Could you just take a look at this list and tell
11 me just very quickly, I mean, briefly, we don't
12 need to spend too much time, what the general
13 subject matter of the case was, that is, what
14 was the case about. Let's start with Bucher
15 versus Medtronic.
16 A. This is a product liability case,
17 and pose your next question.
18 Q. Was it an alleged injury from a
19 product?
20 A. That's correct.
21 Q. What type of injury?
22 A. This was a death in a patient with
23 a complex heart disease, young person, and the
24 alleged failure of the pacemaker was proposed,
25 and that was not proven.

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1 Q. Who were you testifying for in this
2 case?
3 A. For Medtronic.
4 Q. For the defendant?
5 A. Correct.
6 Q. What about the next one, Eckman
7 versus K-Mart?
8 A. This was an occupational disability
9 case. I guess it's a disability case, and in
10 this case, I once again testified for the
11 defendant.
12 Q. For the defendant, and did it have
13 to do with the failure of, or did the condition
14 of the patient have something to do with
15 cardiovascular disease or what?
16 A. This patient had predominantly a
17 heart arrhythmia disturbance as the principal
18 manifestation of cardiovascular problems, and
19 claimed that it was related to the working
20 environment.
21 Q. And you testified for the defense?
22 A. Correct.
23 Q. What about the next one, Fabian
24 versus The University of Minnesota?
25 A. I was personally involved in this

1 case as a defendant.
2 Q. Oh, you were a defendant in this
3 case?
4 A. Correct.
5 Q. Was it alleging some sort of breach
6 of duty on your part or breach of the
7 university?
8 A. No, this was actually alleging
9 breach of duty, initially, as a malpractice
10 case, in which I was one of the principal
11 defendants, but ultimately in the absence of
12 their ability to find anybody that would agree
13 with them, they contended that it was a consumer
14 fraud case.
15 Q. When it listed the University of
16 Minnesota, you're saying that was just one of
17 the defendants, and you were another defendant?
18 A. Correct, there was about three of
19 us, I guess the university, and I was an
20 employee, so I was named specifically.
21 Q. So, you were not an expert witness
22 in that case? Well, expert witness in the sense
23 that you were retained by one side or another to
24 give expert testimony?
25 A. No, this paragraph reads, "Matters

1 in which he has given deposition or trial
2 testimony."
3 Q. That's correct, that's the way it's
4 supposed to. What was the outcome of that case?
5 A. We won that case.
6 Q. What were the allegations, just
7 generally? What did they say you did wrong?
8 A. Well, I hate to say this was an
9 interesting thing, you may not find it
10 interesting, but it was a case in which one of
11 our trainees was undertaking the initial phases
12 of an invasive procedure in a patient at
13 University Hospital. A complication occurred at
14 that initial phase so that we never did
15 undertake the procedure, and in as much as I was
16 not the one sticking the needle in, it was
17 claimed that the patient had assumed that I was
18 going to be doing the whole case and that they
19 didn't understand that this was a teaching
20 institution and the trainees were involved and
21 etc., so it was initially because of the
22 complication they claimed malpractice, but since
23 the complication was a well-known complication,
24 they changed the case to where it was a fraud
25 case because I had purported to be doing the

1 whole procedure. They didn't understand it was
2 a teaching institution, and consequently it was
3 fraudulent on my person not to be the person
4 sticking in the needle and creating the
5 complication.
6 That apparently to my knowledge is
7 the only case of its type, at least in the State
8 of Minnesota.
9 Q. Did you go to trial?
10 A. It did indeed.
11 Q. To the jury?
12 A. Indeed.
13 Q. And the jury sided with you?
14 A. With us.
15 Q. Do you know if it was appealed?
16 A. I know it was not appealed.
17 Q. What about the next one, Mehnke
18 versus San Chez? What was that about?
19 A. This was the medical malpractice
20 case that I gave a deposition in. It was
21 settled out of court. And I testified on behalf
22 of the plaintiff.
23 Q. And what did this case involve,
24 what type of injury?
25 A. This was failure to diagnose a

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Page 109

1 patient with coronary artery disease who was at
2 high risk for complications from coronary artery
3 disease, and the patient had a sudden death
4 episode.
5 Q. What were the allegations against
6 the physician? What did he do?
7 A. Despite having taken medical
8 history, examined the patient and done basic
9 studies, they failed to recognize that the
10 patient's symptoms were due to heart disease.
11 Q. Was smoking involved in that case
12 at all?
13 A. The patient in question may have
14 been a smoker. I can't recall. But I do recall
15 that he was definitely hypertensive and had high
16 cholesterol.
17 Q. So, the patient, plaintiff, went to
18 his physician, and the physician failed to
19 diagnose cardiovascular disease in the patient?
20 A. Yes, but the patient had very
21 classic symptomatology that any medical student
22 should have been able to figure out that this
23 patient was having heart problems.
24 Q. Was smoking one of those factors?
25 MR. CORNFELD: Object,

Page 110

1 repetitious.
2 A. The patient may have been a
3 smoker. I don't recall. I don't recall all the
4 details of the medical history. That wouldn't
5 have been particularly pertinent. And the
6 reason it wouldn't have been pertinent is the
7 patient was, if they were a smoker, they had
8 probably been smoking for many years and they
9 had their heart attack on a specific day.
10 BY MR. MIKHAIL:
11 Q. Did you give a deposition in that
12 case?
13 A. I did.
14 Q. You said you were on the side of
15 the plaintiff?
16 A. That's correct.
17 Q. Who was the Plaintiff's lawyer in
18 that case?
19 A. I don't recall. This was a case
20 from New Mexico.
21 Q. Was it actually, I'm assuming filed
22 in a court in new Mexico then?
23 A. Yes.
24 Q. Do you remember what city?
25 A. Albuquerque.

Page 111

1 Q. What about Sweeney versus -- I'm
2 sorry, what was the outcome of that case, Mehnke
3 versus San Chez?
4 A. That was settled out of court, and
5 the rule was that the settlement was not
6 disclosed to anybody.
7 Q. I understand that, but did trial
8 begin and then it was settled, or was it settled
9 before trial?
10 A. It was settled before trial.
11 Q. And what about Sweeney versus
12 Medtronic?
13 A. This was another product liability
14 case. Once again I testified on behalf of
15 Medtronic, and this was held in South Carolina
16 at Charleston.
17 Q. And Kruse versus Hospital?
18 A. Kruse versus Hospital was a medical
19 malpractice case in which I testified on behalf
20 of the plaintiff against the hospital emergency
21 room physician, and that case was ultimately
22 also settled prior to trial.
23 Q. What were the allegations?
24 A. This was basically malpractice.
25 Basically neglectful care of a patient who

Page 112

1 became desperately ill from the emergency room.
2 Failure to recognize a desperately ill patient,
3 failure to consult, appropriate consultant and
4 failure to transfer the patient to a center that
5 would have been capable of dealing with the
6 problem.
7 Q. Was the patient a cardiovascular
8 disease patient?
9 A. Yes.
10 Q. Do you remember anything about the
11 condition of the patient?
12 A. I remember a lot about the
13 condition of the patient.
14 Q. Was smoking a factor?
15 A. This patient had been a smoker in
16 the distant past, but had not smoked for at
17 least five to eight years prior to this.
18 Q. The allegations, however, if I
19 understood you correctly, is failure in the way
20 the patient was handled and not necessarily
21 failure on a particular physician in providing
22 medical care to the patient? It wasn't like a
23 malpractice case?
24 A. No, this was definitely a
25 malpractice case.

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Page 113

1 Q. Against a particular physician?
2 A. And the hospital, that's correct.
3 Q. But, did the issue of whether or
4 not smoking caused any of the patients'
5 problems, was that an issue?
6 A. Not pertinent to the case.
7 Q. The previous case that we talked
8 about in Charleston, South Carolina, Sweeney
9 versus Medtronic, do you remember who the
10 plaintiff's firm was?
11 A. No, I don't.
12 Q. Let me help you. Do you remember
13 if the Ness, Motley law firm was involved in
14 that case in Charleston?
15 A. I don't remember that name at all.
16 Q. The last one, Glanagan versus
17 Medtronic, I'm assuming you testified for
18 Medtronic?
19 A. That's correct.
20 Q. What was that about?
21 A. Similar product liability case.
22 This one was in Montana, Missoula, and this one
23 as was the case in the Sweeney case, went to
24 trial, and the jury verdict was in the
25 defendant's favor.

Page 114

1 Q. If you will look on the same
2 exhibit, the same page 11 under paragraph 6c
3 where it says, "Dr. Benditt has prepared no
4 notes." Do you see that? What is that
5 referring to, notes of meetings with the lawyers
6 or what?
7 MR. CORNFELD: Let me object. I
8 assume that was referring to whatever was in
9 paragraph 6c.
10 MR. MIKHAIL: I'll tell you, the
11 stipulation and order says that one of the
12 things you are to produce are any documents
13 prepared by the expert. That's all it says.
14 I've got the order here if you want to see it.
15 BY MR. MIKHAIL:
16 Q. My question is, when you say notes,
17 what are you talking about?
18 A. Precisely no notes related to this
19 case or at any of the meetings or any of the
20 articles have been prepared by me and are held
21 by me.
22 Q. One of the documents that is
23 Benditt 5 that we're looking at here, it has a
24 narrative of the various opinions that you are
25 going to give in this case. Did you participate

Page 115

1 in the drafting of Exhibit 5?
2 A. Yes, I did.
3 Q. So, that document does fit into the
4 definition of documents that you prepared?
5 A. Yes.
6 Q. Even though you may not have
7 prepared it completely by yourself, that is a
8 document that you participated in preparing?
9 A. Yes. Are you implying that these
10 are notes?
11 Q. No, no.
12 A. I prepared the document.
13 Q. And also there's another exhibit
14 that I'm going to mark in a moment. Let me go
15 ahead and mark it now, this question, answer,
16 and then we'll go on.
17 (Whereupon, Deposition Exhibit No.
18 6 was marked for identification and a copy is
19 attached and hereby made a part of this
20 deposition.)
21 BY MR. MIKHAIL:
22 Q. Dr. Benditt, I'm going to hand you
23 what's been marked as Exhibit 6, or Benditt 6,
24 which is the disclosure statement given to us in
25 May. Do you recognize Exhibit 6?

Page 116

1 A. I do.
2 Q. Did you participate in drafting or
3 preparing the Exhibit 6?
4 A. I did.
5 Q. Then going back to Benditt 5 where
6 it says Dr. Benditt has prepared no notes, this
7 is just, it means nothing. I'm just saying,
8 other than these two documents, Exhibit 6 and
9 Exhibit 5, did you prepare or assist in
10 preparing any other documents in connection with
11 your testimony?
12 A. Not that I can recollect.
13 Q. That's fine.
14 MR. CORNFELD: Are you saying that
15 under paragraph 6c we were supposed to list the
16 disclosure itself?
17 MR. MIKHAIL: No, no, I'm just
18 trying to make sure it's clear. No, no. I'm
19 just trying to make sure that I know of every
20 document that this witness has either prepared
21 or participated in preparing, and that's all.
22 MR. CORNFELD: Okay.
23 BY MR. MIKHAIL:
24 Q. Let's look at Exhibit 6, the
25 disclosure statement. Did you -- well, let me

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Page 117

1 ask you this. Did you draft this by yourself or
2 did you --
3 A. Yes, I basically drafted this by
4 myself, and it's, I'm sure, went through some
5 revisions.
6 Q. How did that work? Did you submit
7 it to one of the lawyers and --
8 A. I think that this draft, if I'm not
9 mistaken, and I might be mistaken, is very
10 similar to one that was prepared for the
11 Minnesota case, and we essentially adapted it
12 for purposes of the Oklahoma case.
13 Q. What were required under the order
14 of Oklahoma are documents that you prepared in
15 this case. So, what I'm saying, as to this case
16 itself, Exhibit 6, was there a process of
17 drafting for Oklahoma, or was it simply taking
18 the Minnesota disclosure and titling it for
19 Oklahoma?
20 A. No, it was a redraft for the
21 Oklahoma case, because there apparently are
22 differences in the case that perhaps are beyond
23 my level of legal expertise.
24 Q. But, you drafted the initial draft?
25 A. Yes.

Page 118

1 Q. And who did you submit it to?
2 A. I'm sure I submitted it to the
3 legal team that I was working with, and they
4 ultimately submitted it to you, I suspect. Do
5 you recall if they made any changes or suggested
6 changes to the document?
7 A. I don't recall their suggesting any
8 changes. The only thing that I do recall, since
9 I base this on what I had said in Minnesota and
10 there were some aspects of the Minnesota case
11 that I guess are not pertinent in Oklahoma,
12 there was perhaps a segment taken out.
13 Q. Other than the things that were not
14 pertinent to Minnesota, were there any
15 substantive changes made to the --
16 MR. CORNFELD: You mean, Oklahoma?
17 BY MR. MIKHAIL:
18 Q. No, other than Minnesota, other
19 than the parts that pertain to Minnesota that
20 they didn't want, were there any substantive
21 changes?
22 A. No, the opinions basically are the
23 same.
24 Q. Did you keep any copies of the
25 document with any changes made by the attorneys?

Page 119

1 A. No.
2 Q. What about Exhibit 5, the
3 disclosures, the seven day disclosure? I want
4 to ask you for the first few pages. The first
5 page entitled paragraph 6a, which is the list of
6 your opinions, and it goes all the way to page
7 seven, did you draft that portion of Exhibit 5?
8 A. Yes, I did.
9 Q. Did you draft it and then submit it
10 to the lawyers?
11 A. That's correct.
12 Q. Did the lawyers make any changes to
13 it at all from what you submitted to them?
14 A. I believe that we may have
15 discussed segments, but I don't recall any
16 specific items and problems. It was more
17 related to the style of my writing.
18 Q. Do you recall any substantive
19 change? For instance, did they say, no, you
20 can't say this, change it?
21 A. No, absolutely there was none of
22 that.
23 Q. No substantive change?
24 A. No.
25 Q. Did you keep any copies of any

Page 120

1 documents that contained what you drafted with
2 any changes by the lawyers?
3 A. No.
4 Q. I'm not suggesting there was one.
5 Was there one?
6 A. No, no.
7 THE VIDEOGRAPHER: Going off the
8 video record. The time is now approximately
9 12:26 p.m. Elapsed time is 2 hours, 47 minutes
10 and two seconds.
11 (WHEREUPON A SHORT RECESS WAS HAD)
12 THE VIDEOGRAPHER: We're back on
13 the video record. The time is now approximately
14 12:37 p.m. Elapsed time is two hours, 58
15 minutes and 31 seconds.
16 BY MR. MIKHAIL:
17 Q. Dr. Benditt, I'm going to hand you
18 again what we've marked as Exhibit 6, the
19 disclosure statement. I'm going to ask you a
20 few questions about that. Would you look down
21 under the paragraph that's marked paragraph
22 number 1 and go down to the sentence about the
23 sixth or seventh line, I think it starts with
24 "Accurate diagnosis of cardiovascular disease."
25 Do you see that sentence?

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A. Yes, I do.
Q. The statement reads. "Accurate diagnosis of cardiovascular disease involves thorough assessment of an individual patients medical history, clinical systems, laboratory values and diagnostic texts and procedures." Do you see that?
A. Yes, it did read clinical symptoms just for accuracy.
Q. I'm sorry, I get tongue tied sometimes. You are referring there to diagnosis of cardiovascular disease in an individual patient, correct?
A. Yes.
Q. You are not making reference to the study of incidence of disease in populations or subgroups of populations, correct?
A. Not quite correct. The implication here is that in order to ascertain whether populations or sub groups of populations have cardiovascular disease, one has to know in each of the individuals who comprise that population, whether they have cardiovascular disease, and in order to establish that in those singular individuals, you'd have to have at least this

Q. I understand that. But, are you not referring to, perhaps, a study of individual records of a sample that could produce statistically significant results as opposed to having to study each individual member of that population?
A. Well, I think that in order to have data on a population, somehow you have to know the data on the individuals in that population. I don't know otherwise how you would qualify them as being members of that group.
Q. But, your testimony is that one cannot give a reliable scientific or credible scientific opinion about the instance of cardiovascular disease in a population or sub group of that population without actually examining every member of that population. That's your opinion?
A. That's my opinion.
Q. And when someone does that, when an epidemiologist such as Dr. Blackburn or any other epidemiologist that specializes in cardiovascular disease says that, I have looked at the various studies of various populations, not one study, but numerous studies, I have

information.
Q. But, are you saying that in order for an expert opinion to be expressed about the incidence of cardiovascular disease in a population or in a sub group of the population, for instance, the Medicaid population out of the Oklahoma population, that one has to examine every single member, individual member of that population?
A. Yes.
Q. Is that what you're saying?
A. Yes. Just by way of explanation, many times epidemiologic studies are done on other bits of information that are sort of questionable. For example, you commonly see in epidemiology reports, even moderate ones, that they will use ICD dione codes. Absolutely useless information to study populations. The quality of that input is so questionable that any inferences you made in terms of the output of those studies has got to be nonsense, so that in order to have a quality study, you need to have quality data, and that's basically my position, that you need to know that in individuals.

considered the totality of the evidence, and I can reach a conclusion as to the incidence of disease, of cardiovascular disease in that population, you're saying that that is unpopular to do?
MR. CORNFELD: Object to mischaracterization. I think that misstates what Dr. Blackburn has done. Go ahead.
BY MR. MIKHAIL:
Q. You're saying without information on every specific member of the Oklahoma Medicaid population, an epidemiologist such as Dr. Blackburn cannot reach a conclusion about the incidence of cardiovascular disease in that population?
MR. CORNFELD: Same objection. It misstates what Dr. Blackburn has done.
A. He can reach a conclusion. The issue is not whether he can reach a conclusion. The issue is whether the conclusion is right or wrong.
BY MR. MIKHAIL:
Q. Okay, but I thought I understood you to say that it is impossible to reach a conclusion without looking at every individual

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Page 125

1 member of that population?
2 A. Well, if I said it's impossible to
3 reach a conclusion, I misspoke, because I would
4 never say that. We can reach conclusions about
5 all sorts of things with flimsy evidence. The
6 issue as always, what is the precision with
7 which, or the correctness of that conclusion,
8 and one would have to say in epidemiologic
9 studies, and I'm sure that epidemiologists would
10 agree with me, that if you had the opportunity
11 to assess every patient in the population, your
12 assessment of correctness of your conclusion
13 would be, would have a far higher level of
14 confidence than if you only sample a certain
15 proportion of the population that you're
16 purporting to characterize.
17 Feasibility may make it such that
18 you can't examine every patient, but the smaller
19 your sample size and the less complete your
20 evaluation and the more distant your data
21 sources are from the individual patient, the
22 less reliable the outcome is going to be, and
23 consequently the less secure are your
24 conclusions.
25 Q. Well, isn't your testimony, Dr.

Page 126

1 Benditt, that even when you look at an
2 individual patient, individual member of the
3 Medicaid population, in Oklahoma or anywhere
4 else, but let's deal with Oklahoma, that because
5 of the complex nature of the various risk
6 factors for cardiovascular disease, that even
7 then, even upon examining the individual
8 patient, that you cannot reach a conclusion on
9 the causation issue as to smoking and the
10 cardiovascular disease in that patient. Isn't
11 that your proposition?
12 A. Yes, in essence, you've cited it
13 very nicely.
14 Q. If that is the case, then, what
15 does it matter if you review 30 or 35 Medicaid
16 recipient depositions or you review all of the
17 members of the population, if you can't reach a
18 conclusion on causation between smoking and
19 cardiovascular disease? What does it matter if
20 you've reviewed 30 or 35 or every one of them?
21 MR. CORNFELD: Object to the form
22 of the question. The statement from the report
23 didn't refer to smoking, it referred to
24 diagnosis of cardiovascular disease.
25 MR. MIKHAIL: I'm still not with

Page 127

1 that question, Rick, I've moved on.
2 BY MR. MIKHAIL:
3 Q. Go ahead.
4 A. I was going to actually make the
5 same point, although I just wanted not to give
6 you a hard time about your question, but simply
7 to say that we've changed topics here.
8 Q. Yes, we moved on from this right
9 here.
10 A. And it's a very important change
11 because the statement in my disclosure refers to
12 making a diagnosis of cardiovascular disease,
13 not establishing a cause. In terms of
14 establishing a cause of cardiovascular disease
15 in a given patient, that is often very
16 difficult, and I would agree with your statement
17 that in regard to smoking, it's basically
18 impossible. There are other incidents in which
19 you can establish a causal relationship in heart
20 disease as part of the examination. But, not
21 vis-a-vis smoking.
22 Q. I know I moved on, and I apologize,
23 I didn't mean to deliberately confuse you, but
24 if we're talking about the causal relationship
25 between smoking and CVD, as the proposition I

Page 128

1 stated, as you said, it was correct, then it
2 doesn't really matter, it's not useful to study
3 30 Medicaid recipients or all of them, isn't
4 that correct?
5 A. In terms of causation, it's not.
6 In terms of risk factors for cardiovascular
7 disease and other things that one might modify
8 to reduce the incidents of other diseases in
9 that population, it is, and that's basically
10 what the epidemiology studies of Dr. Blackburn
11 and many, many others have tried to do.
12 Q. But, as to causation, you don't
13 believe it's necessary or useful to do that, to
14 review those individual Medicaid recipients or
15 the entire population?
16 A. I wouldn't characterize it as not
17 useful. I would say that it's not been
18 effective to date.
19 Q. I mean, not useful in the sense of
20 being necessary in order for you to render the
21 opinion that you've given on the causation
22 issue?
23 A. It's not necessary, that's correct,
24 because in essence, it seems that nobody has
25 been able to identify a causal relationship

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Page 129

1 between smoking and cardiovascular disease in
2 individuals or populations. There's always the
3 possibility that there may be one patient out
4 there in which somebody can take a relationship
5 between an event and an outcome and say the two,
6 one was caused by the other, but that's not to
7 my knowledge demonstrated in the smoking issue.
8 Q. Who would that be? Somebody that
9 has no risk factors other than smoking, for
10 instance, somebody like that?
11 A. It would have to be a very unusual
12 case. I'm not even sure I would necessarily buy
13 that one. I think that you would have, you
14 might speculate on how you might come to that,
15 but it's obviously very difficult. It would
16 have to be a very unique situation.
17 Q. I guess what I'm trying to do, and
18 I want to make myself clear. You came into this
19 case before you looked at the Medicaid recipient
20 depositions, I assume you did look at some
21 Medicaid recipient depositions?
22 A. I have not.
23 MR. MIKHAIL: My understanding is
24 that Medicaid recipient depositions and their
25 medical records were a part of what he relied

Page 130

1 on.
2 MR. CORNFELD: It's not in the
3 disclosure.
4 BY MR. MIKHAIL:
5 Q. Look at Exhibit 6 at the last
6 paragraph. It says, number 3 says, you're
7 relying on medical records and questionnaires.
8 That was part of the Medicaid recipient
9 material.
10 MR. CORNFELD: I bet that's not in
11 the seven day disclosure.
12 MR. MIKHAIL: No, it's not, but I
13 didn't believe it excluded everything that was
14 before.
15 MR. CORNFELD: I cannot tell you
16 what is in there except that maybe somebody at
17 one point thought Dr. Benditt might be asked to
18 do that, but he has not been asked to look at
19 that.
20 BY MR. MIKHAIL:
21 Q. You have not been asked to review
22 individual Medicaid recipient depositions or
23 medical records or questionnaires for Oklahoma?
24 A. No, I haven't.
25 Q. And you have not done that?

Page 131

1 A. No.
2 MR. MIKHAIL: I'm sorry, I thought
3 that was part of it.
4 BY MR. MIKHAIL:
5 Q. Dr. Benditt, if you look on Exhibit
6 6, the second paragraph, where it says, "Many
7 risk factors have been identified for
8 cardiovascular disease and the role of these
9 risk factors including smoking is not fully
10 understood." Do you see that?
11 A. Yes, I do.
12 Q. Then it goes on to say, "In fact,
13 the medical and scientific community have not
14 identified all risk factors for cardiovascular
15 disease nor have they established the precise
16 pathophysiological mechanism for the development
17 of cardiovascular disease." Do you see that?
18 A. Yes, I have.
19 Q. Let me ask you, isn't it true that
20 no matter how many risk factors we discover or
21 learn, I know one of the articles lists 246,
22 even if there are hundreds more, the question
23 is, no matter how many risk factors that we are
24 able to identify, haven't we identified the main
25 ones?

Page 132

1 A. Well, I guess the issue is have we
2 identified the risk factors that account for the
3 predominant numbers of heart disease in the
4 population, is another way of asking that
5 question, and is that a fair sort of just --
6 Q. That's fine.
7 A. And I think that it's well
8 documented, even by individuals such as Dr.
9 Kannel from Framingham and others that at least
10 half of the incidence of heart disease in the
11 U.S. population cannot be accounted for by the
12 known risk factors, so that you would have to
13 say, that 246 or 500 aside, or the top five or
14 ten, however you want to classify them, only
15 account for, we'll say, roughly half of the
16 heart disease that occurs in the population,
17 coronary artery disease, to be more specific.
18 So, the proposition that we've
19 identified the major league players here has to
20 be looked at with some skepticism. There are
21 other factors, perhaps, that we desperately need
22 to know about in order to have a major impact on
23 this condition.
24 Q. But, notwithstanding the fact that
25 there are many that we may not have identified,

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Page 133

1 that in and of itself doesn't diminish the
2 importance of the major risk factors such as
3 hypertension, cholesterol, smoking, that are
4 listed as some of the main or classic risk
5 factors. The fact that there may be hundreds
6 more does not diminish the importance of these
7 risk factors of cardiovascular disease, does it?
8 A. Well, it does, because you made
9 several interesting comments in your question
10 that I would have to take issue with.
11 Q. Forgive me. Lawyers do that. You
12 understand the question?
13 A. I understand the question, and
14 maybe I can try to frame it in a form that will
15 tell you why I disagrees with your proposal, and
16 that is, first of all, you used the term major
17 risk factors, and we have never defined that in
18 this meeting, and I think we need to go back and
19 do that, that is define it in the epidemiology
20 world, and we have not done it here, so I think
21 one, I would contend that some of the risk
22 factors that you consider to be major are not
23 indeed major even though they're popular.
24 Secondly, if only half the disease
25 is accounted for by known risk factors, if the

Page 134

1 other half were accounted for by ten thousand
2 risk factors, then yes, there probably would be
3 a case to be made for some of what you said.
4 What if there's only one risk factor that
5 accounts for 49 percent of the residual unknown
6 and all of a sudden the major risk factors as
7 you quote them pale in comparison.
8 So, we can't assume that just
9 because the popular risk factors are popular
10 today that they are indeed the most important.
11 But, you know, I'm speculating, but just trying
12 to frame your question in a way that I think we
13 need to keep our radar screen open to other
14 possible contributors to coronary disease.
15 Q. Do you know how much smoking
16 accounts for in cardiovascular disease?
17 A. Well, there are different numbers
18 that are provided, but the conventional risk
19 factor in terms of relative risk is about 2. It
20 varies in the 1.7 to 2.3 range, and there's
21 other numbers, but 2 is a relatively common
22 number for many studies.
23 Q. That's the relative risk factor.
24 I'm talking about smoking itself as a risk
25 factor, how much does it account for for

Page 135

1 cardiovascular disease?
2 MR. CORNFELD: Object to the form
3 of the question.
4 A. Again, all we can say is you can do
5 the arithmetic any way you want to do it, and
6 it's done certain ways in the Surgeon General's
7 report and the American Heart Association.
8 BY MR. MIKHAIL:
9 Q. How do you do it?
10 A. All I say to myself and to patients
11 and to students is that there is a relative risk
12 associated with smoking, and that changes
13 depending upon the population that you're
14 studying, and the average number is 2, but
15 depending on the circumstances, it may be less
16 than that or more than that. I don't believe
17 they ever make any statement about how much
18 additional death might be contributed by
19 smoking.
20 Q. So, you can't tell me today?
21 A. I can't tell you today.
22 Q. Dr. Benditt, the fact that we don't
23 know all risk factors or there may be hundreds
24 out there that we don't know that may account
25 for the 49 percent, or if one accounts for the

Page 136

1 49 percent, that being the case, assuming that's
2 true, I don't know for sure, but that being the
3 case, that's no reason not to as a medical
4 professional, as a cardiologist, that is not a
5 reason not to advise patients not to start
6 smoking, is it?
7 A. Agreed.
8 Q. And it's not a reason to not advise
9 patients to stop smoking, is it?
10 A. Agreed.
11 Q. Let's talk just briefly about
12 statistical association and causal
13 relationship. Would you agree with me that the
14 stronger the statistical association, the better
15 or more scientific you're able to give an
16 opinion as to cause and effect relationship?
17 A. Well, statistical association is
18 only one of the various key components of the
19 causal issue, and if you will, maybe one fourth
20 or one fifth of the total picture, so the answer
21 intuitively would seem to be yes, but
22 statistical associations are replete with
23 problems, and so I think that if we're going to
24 talk about causation, we need to discuss not
25 just statistical associations, but also the

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Page 137

1 other factors, and then we also, if we want to
2 focus on statistical associations, we also need
3 to discuss what is a strong statistical
4 association and what isn't.
5 Q. I understand that, and I really am
6 not trying to do that, get into the real
7 specifics. I'm simply asking as a general rule,
8 isn't it true that the stronger the statistical
9 association, the better able we are to make a
10 judgment on causation?
11 MR. CORNFELD: Object to the form
12 of the question.
13 A. And I'll say that the stronger the
14 statistical association, the stronger we have
15 for one component of the causation.
16 BY MR. MIKHAIL:
17 Q. Okay, that's fair enough. Do you
18 believe that the statistical association with
19 smoking is an example of a very strong
20 statistical association?
21 A. In epidemiologic terms, the answer
22 is no.
23 Q. It is not?
24 A. That's correct, it's not.
25 Q. Can you name any other risk factor

Page 138

1 for cardiovascular disease other than smoking
2 that has a stronger statistical association?
3 A. Yes, I can.
4 Q. Go ahead.
5 A. Family genetic pattern, male
6 gender, LDL, lipid profile.
7 Q. Let's stick with the modifiables.
8 A. LDL, lipid profile. Hypertension
9 probably is about equivalent to smoking. Type A
10 personality, or psychosocial environment which
11 to some extent is modifiable.
12 Q. I didn't mean to interrupt you, are
13 you finished?
14 A. Yes, I can think of others, but.
15 Q. You're saying a type A personality
16 has a stronger statistical association with
17 cardiovascular disease than smoking?
18 A. I'm saying the psychosocial
19 environment including personality type does,
20 yes.
21 Q. Could you give me a source of where
22 in the literature or elsewhere that would
23 support your last statement about the strength
24 of the association of type A personality being
25 either equal to or greater than smoking?

Page 139

1 MR. CORNFELD: He said psychosocial
2 environment.
3 BY MR. MIKHAIL:
4 Q. Psychosocial environment.
5 A. I think we can start with Hopkins
6 at the top of the list, and I think that in
7 terms of quantifying things, we have identified
8 the psychosocial environment. For example,
9 being widowed or being a widower is a very
10 strong predictor of tendency to coronary artery
11 disease, and the fact that it is a remediable
12 condition.
13 Q. And this is in the documents you're
14 relying on, it's exhibit --
15 A. It's actually number 1 on the list,
16 the 246 risk factors paper that you alluded to
17 earlier.
18 Q. Yes, Hopkins. Any other?
19 A. There probably are, but I can't
20 recall them offhand.
21 Q. This is the one in the University
22 of Utah?
23 A. That's correct.
24 Q. Yes, Hopkins article. Can you
25 identify any others on this list?

Page 140

1 A. Not offhand, but I'm sure if I went
2 through them, I could identify them. It's
3 certainly important to point out that the type A
4 personality, including the psychosocial issue,
5 but predictor type A personality was only
6 identified in the Framingham study if you recall
7 in the mid sixties. It never was part of the
8 original concern, and as soon as they entered it
9 in, all of a sudden, issues such as smoking
10 tended to become less critical components in the
11 risk factor, and a lot of apologies have been
12 seemingly written about that.
13 Q. What does an independent risk
14 factor mean as opposed to a risk factor?
15 A. There are statistical tests of a
16 variety of types, that can look at risk factors
17 and try to weed out those that rely on each
18 other from those that are independent of each
19 other, and those statistical tests are commonly
20 used in epidemiologic studies to try and isolate
21 individual risk factors in terms of their
22 importance.
23 Q. Doesn't the Wilson article do that
24 in some fashion or not?
25 A. It does. Can you just take a break

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Page 141

1 for a moment? My pager just went off. I should
2 just answer this.
3 THE VIDEOGRAPHER: Going off the
4 video record. The time is now approximately
5 1:05 p.m. The lapse time is 3 hours, 24 minutes
6 and 59 seconds.
7 THE VIDEOGRAPHER: We're back on
8 the video record. The time is now approximately
9 1:16 p.m. Elapsed time is 3 hours, 37 minutes
10 and 27 seconds.
11 BY MR. MIKHAIL:
12 Q. Dr. Benditt, would you look at
13 Exhibit 5, I believe it's under this, yes. Page
14 5. It's the seven day disclosure. The
15 paragraph at the top that starts with, "Although
16 cigarette smoking," do you see that?
17 A. Yes.
18 Q. It says, "Although cigarette
19 smoking has been identified as a risk factor for
20 cerebrovascular disease, the consistency of data
21 relating cigarette smoking to cerebrovascular
22 disease including stroke has been questioned.
23 In fact it has been reported that number one,
24 cigarette smoking has been less consistently
25 predictive of cerebrovascular disease as

Page 142

1 compared to other cerebrovascular risk
2 factors." What literature supports that
3 statement?
4 A. I would have to go back and take a
5 closer look at that, although it's fair to say
6 that the strength of the association is even
7 available from Framingham data.
8 Q. From the list that, of reliance
9 material here, is there any particular reliance
10 material item that you can point me to that
11 would support that statement?
12 A. Let me just go through this. I
13 think it comes up in the second one, Kannel. I
14 believe it's also dealt with in Stokes.
15 Q. On page 4?
16 A. Page 3, I think it is, Wolf on page
17 3. Marmot on page 3. I think each of these on
18 page 3, Hart included, and Longstreth.
19 Q. Anything else?
20 A. I'm less certain, but I'd also want
21 to look again at Freund, et al on page 5 and
22 Brockie listed on page 4.
23 Q. Have you looked at the results of
24 the CPS 1 and CPS 2 surveys?
25 A. I don't recall those, no. What

Page 143

1 does CPS stand for?
2 Q. Current population survey.
3 A. No, I don't believe so.
4 Q. Look at the next paragraph, which
5 is the second paragraph on page 5 of that same
6 exhibit, that starts with hypertension is the
7 most consistent predictive risk factor. Do you
8 see that?
9 A. Yes.
10 Q. Go to the last sentence in that
11 paragraph, the ones that starts with "Some
12 literature has even reported." Do you see that?
13 A. Yes.
14 Q. Okay, "Some literature has even
15 reported that cigarette smokers have lower blood
16 pressure relative to non-smokers." Is that
17 because they don't eat as much because of their
18 smoking and they don't get fat, or is there some
19 other reason?
20 A. I wouldn't know the reason. I
21 don't think the data supports that smokers don't
22 eat as much. I think the data that I've read
23 would suggest that the caloric intake of smokers
24 and non-smokers is comparable, but it is true
25 that smokers tend to have lower average body

Page 144

1 weight than non-smokers.
2 Q. Which would in part explain lower
3 blood pressure?
4 A. It could, but there may be stress
5 factors. Some people claim that one of the
6 reasons that ex-smokers -- let me rethink that.
7 I guess I shouldn't say anything about
8 ex-smokers. I think it's probably better to say
9 that it has been claimed, and I think it's
10 actually perhaps best laid out -- that must be
11 Brody, that article on page. I think it's a
12 misprint here in the disclosure.
13 Q. You mean, the statement is a
14 misprint?
15 A. No, no. The name, I said earlier
16 Brockie, and it should be Brody. I'm sorry
17 about that.
18 Q. That's fine.
19 A. It's Brody, and I think it's
20 misstated in there, the issue of the stress
21 relieving effect of smoking. I don't know that
22 that's well supported, but it may also account
23 for your observation of the lower blood
24 pressure.
25 Q. Dr. Benditt, you're not suggesting

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Page 145

1 that smoking is good for you for the blood
2 pressure level, are you?
3 A. No, I'm not suggesting that at all.
4 Q. Go down under the section of
5 peripheral vascular disease. Go down to the
6 third paragraph, the paragraph that starts with
7 "Numerous risk factors." Do you see that?
8 A. Yes.
9 Q. In the center of the paragraph,
10 there's a sentence that starts with "although,"
11 do you see that, "although cigarette smoking"?
12 A. Yes.
13 Q. I'll again reading from the
14 sentence. "Although cigarette smoking has been
15 reported to be statistically associated with
16 intermittent claudication, most smokers do not
17 develop this condition." Do you see that?
18 A. Yes, I do.
19 Q. Is there any particular reason why
20 you stated this conclusion or this opinion in
21 this fashion, "Although cigarette smoking has
22 been reported to be statistically associated
23 with intermittent claudication, most smokers do
24 not develop this condition," as opposed to that
25 most smokers, I'm sorry, most patients with

Page 146

1 peripheral vascular problems suffering from
2 intermittent claudication are smokers? Do you
3 understand the question?
4 A. Yes, I understand the question.
5 Q. Can you answer it?
6 A. I think the important point, why
7 did we chose to, or why did I chose to use
8 intermittent claudication as an example is
9 because that's the way the Framingham study
10 tends to look at peripheral vascular disease,
11 and in the population study that seemed to
12 provide the largest body of data from which one
13 could work, and it's an important clinical
14 condition to boot, so that's why.
15 In terms of the issue of cause is
16 important, because if you made the claim that
17 cigarette smoking causes atherosclerotic
18 disease, including atherosclerotic
19 manifestations and peripheral vascular disease,
20 you would expect that that cause would result in
21 disease in the vast majority of the population,
22 and that is not true. The possibility that
23 cigarette smoking maybe aggravates an underlying
24 problem is really the way you've laid it out,
25 and that wasn't what my point was.

Page 147

1 Q. What I'm trying to get at is if
2 we're dealing with the issue of causation of
3 peripheral vascular disease, then which is more
4 important, in trying to arrive at a conclusion
5 about causation or trying to determine
6 causation, which is more important, to look and
7 say that the vast majority, I'm going to use the
8 figure of 70 percent because that's what's
9 reported in the literature according to my
10 understanding, 70 percent of patients suffering
11 from intermittent claudication, peripheral
12 vascular disease are smokers, is it more
13 important in determining the causation issue
14 looking at that statistic in that fashion as
15 opposed to saying that most smokers do not
16 develop intermittent claudication?
17 MR. CORNFELD: Object to the
18 improper assumption or statement in the question
19 about 70 percent because there are many studies
20 with many different percentages.
21 MR. MIKHAIL: I'll use most. It
22 doesn't matter. Your objection is noted.
23 A. I think my statement is more
24 pertinent to causation because the issue of what
25 is the consistency of the relationship between

Page 148

1 smoking and disease can be looked at is if
2 people -- or maybe I should explain it more
3 generally. What is the consistency of the
4 relationship between the cause and the disease,
5 is there a consistent relationship. That's one
6 of the foundation points as you're well aware of
7 the causal argument, and so consistency, as a
8 matter of fact, is very important to
9 demonstrate, and this statement basically says
10 that you can have a lot of people with the
11 purported cause, but you have no disease, so
12 there's an inconsistency of that relationship.
13 BY MR. MIKHAIL:
14 Q. So, you believe that the way you
15 phrased it is the question to pose in order to
16 better understand causation?
17 A. I do, because just to preempt your
18 next question, the notion of very great
19 importance to physicians is are there risk
20 factors that aggravate predetermined or
21 preexisting disease, and that's really the point
22 that I believe your statement addresses.
23 Q. Okay, but your approach to this,
24 and your statement here that most smokers do not
25 develop this condition, meaning intermittent

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Page 149

1 claudication and peripheral vascular disease,
2 isn't that the same way of saying most smokers
3 do not develop lung cancer even though 90
4 percent of lung cancer victims are smokers?
5 You're doing it exactly the same way with
6 peripheral vascular disease and intermittent
7 claudication as the statement that I just made
8 about lung cancer, isn't it?
9 A. Well, I'm not an expert on lung
10 cancer, so I would probably prefer not to use
11 that as a parallel example, but the point that
12 I'm trying to make is, is there a consistency of
13 relationship that supports a cause and effect
14 notion.
15 Q. But, my analogies to this on the
16 issue of determining causation, what you're
17 doing here with intermittent claudication and
18 peripheral vascular disease is the same thing
19 that is done with lung cancer, the argument that
20 most smokers don't get lung cancer when the
21 statement of most lung cancer victims are
22 smokers is the flip side or the other way of
23 saying it. You're doing it the exact same way
24 as the example I'm giving with lung cancer,
25 correct?

Page 150

1 MR. CORNFELD: Object, lack of
2 foundation. He's already told you he's not an
3 expert on lung cancer.
4 BY MR. MIKHAIL:
5 Q. Do you know --
6 A. I understand what you're saying,
7 and the analogy that you are providing seems
8 parallel, but the points that I'm trying to
9 address are if you're speaking about cause, is
10 that the cause has to be supported by a number
11 of pivotal points, and all I'm saying is that in
12 this instance, one of the pivotal points,
13 consistency of relationship, may be questioned.
14 I'm not trying to imply that other points
15 related to whether it's lung cancer or any other
16 disease might be strong or weak.
17 Q. I understand that, but you admit
18 the parallel?
19 A. I admit the parallel that you're
20 trying to make.
21 Q. And the approach that you're
22 approaching with peripheral vascular disease and
23 intermittent claudication is the same approach
24 of the example that I gave you, the argument or
25 the approach that most smokers do not develop

Page 151

1 lung disease, isn't it?
2 MR. CORNFELD: Same objection to
3 lack of foundation.
4 A. It is, but I think about cause as
5 also including specificity apart from
6 consistency of relationship. Specificity,
7 strength of relationship and temporal
8 concordance of relationship as well as other
9 factors, so this is just one of the points that
10 I'm using to demonstrate that perhaps there is a
11 weakness in that relationship.
12 BY MR. MIKHAIL:
13 Q. Right. I understand that, Dr.
14 Benditt, but in determining causation, you think
15 it is better and more reliable to pose or frame
16 the question in the way that you've done here as
17 to peripheral vascular disease than the way I
18 put it, and that is that most peripheral
19 vascular disease or intermittent claudication
20 conditions are smokers?
21 A. Yes.
22 Q. Okay. What is the role of synergy
23 in the various risk factors in cardiovascular
24 disease?
25 A. I can't answer that over the global

Page 152

1 scope of all the risk factors that are
2 associated. It's been proposed that certain of
3 the risk factors, when added together, result in
4 a greater magnitude of risk than one would have
5 anticipated had you looked at them individually.
6 Q. Do you have an opinion if that is
7 true in fact?
8 A. Well, given the fact that there's
9 hundreds of risk factors, I would probably
10 venture to guess that there are synergies among
11 then, but it's not well demonstrated with
12 respect to the risk factors that we've been
13 discussing.
14 Q. Is it your opinion that there's,
15 that it has not been demonstrated that there is
16 synergy between smoking and hypertension,
17 cholesterol?
18 A. That's correct. If you look at the
19 principal studies that have examined this issue,
20 the risk remains at 2.
21 Q. Dr. Blackburn in one of the
22 opinions that he gave says, "There is a
23 synergistic effect of combining risk factors.
24 Smoking, cholesterol and hypertension synergy
25 equals increased risk." Do you disagree with

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Page 153

1 that statement?
2 A. Well, I think that he makes a
3 statement. We have to go through it and define
4 each point, but I would say that in general
5 terms, I disagree with that.
6 Q. And the section from Harrison's
7 Principals of Internal Medicine that we looked
8 at, the sentence that you read, but you're
9 welcome to look at it again since you don't have
10 it in front of you, I will read it, it says,
11 "Cigarette smoke, hypertension and
12 hypercholesterolemia are the three major CHD
13 risk factors. Smoking acts both independently
14 of and synergistically with these other CHD risk
15 factors. Two risk factors may produce a
16 fourfold increase in CHD risk and three risk
17 factors may produce an eightfold increase in CHD
18 risk." Do you agree or disagree with that?
19 A. You'll notice at least as I can
20 tell from that quick look there's not a whole
21 lot of referencing going on there. The data
22 that I've reviewed and were available in the
23 room to look at, if you wish, are that in each
24 patient population, whether they have high
25 cholesterol or they're hypertensive or they have

Page 154

1 both hypercholesterolemia and hypertension,
2 smoking doubles the risk of the manifestations
3 of cardiovascular disease in that population.
4 So, in the base line population,
5 who have no other risk, none of these other two
6 risk factors, we can go through and we can show
7 you data in the literature that basically says
8 it doubles. Everything is always a relative
9 restriction of 2, more or less. So, that's not
10 synergy.
11 Q. But, do you disagree with the
12 portion I read to you from Harrison's
13 notwithstanding that you don't see any
14 references there?
15 MR. CORNFELD: He just explained it
16 to you.
17 A. I think the essence of my comments
18 would be I disagree.
19 BY MR. MIKHAIL:
20 Q. You disagree, and you disagree with
21 Dr. Blackburn's statement on that issue I read
22 to you?
23 A. Yes, I would have liked Dr.
24 Blackburn to have perhaps provided some data
25 references to support that statement.

Page 155

1 Q. I'm going to read to you from page
2 5 of the 1983 Surgeon General's report on
3 cardiovascular disease. "Cigarette smoking also
4 acts synergistically with the other major risk
5 factors to greatly increase the risk of CHD."
6 Do you agree or disagree with the surgeon
7 general?
8 MR. CORNFELD: Would you mind
9 reading that again?
10 Q. Sure. "Cigarette smoking also acts
11 synergistically with the other major risk
12 factors to greatly increase the risk of CHD."
13 Do you agree with that statement of the Surgeon
14 General?
15 A. No, I don't.
16 Q. Again, I didn't mean to use this as
17 an exhibit, Rick, so I don't have a copy of it,
18 but somebody handed me a brochure of the
19 American Heart Association, and I'm just going
20 to show that to you for just a moment. This is,
21 let me just identify it for the record. It's an
22 American Heart Association brochure entitled,
23 "Smoking and Heart Disease." It's apparently
24 three publications, 1986, 1992 and 1995.
25 MR. CORNFELD: Do you mind if I see

Page 156

1 it?
2 MR. MIKHAIL: Just hand it to you?
3 MR. CORNFELD: Yes, I'm sorry, I've
4 interrupted you. You said it bears something?
5 MR. MIKHAIL: I'm sorry?
6 MR. CORNFELD: I interrupted your
7 identification of it.
8 MR. MIKHAIL: American Heart
9 Association publication called "Smoking and
10 Heart Disease," and it shows copyright, 1986,
11 1992, 1995, so I'm assuming it was reprints, and
12 on page three of that publication, let me read
13 the statement to you.
14 MR. CORNFELD: May I see it first?
15 MR. MIKHAIL: The cover?
16 MR. CORNFELD: I'd like to see the
17 whole thing, actually.
18 MR. MIKHAIL: I've got my notes on
19 it, so.
20 MR. CORNFELD: I promise not to
21 look at your notes. Or if I can't, I promise to
22 forget about them. You're going to ask about
23 page 5?
24 MR. MIKHAIL: Three.
25 MR. CORNFELD: Page 3? This

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Page 157

1 underlined portion?
2 MR. MIKHAIL: Yes.
3 BY MR. MIKHAIL:
4 Q. Dr. Benditt, the statement reads,
5 "In both men and women smoking interacts with
6 high blood cholesterol to markedly increase the
7 risk for CVD. In other words, people who smoke
8 and have high cholesterol levels have a higher
9 risk of CVD than the sum of each risk factor by
10 itself. Also, smokers --" let me ask you this.
11 Do you agree with this statement?
12 A. Well, you know, that's sort of
13 standard dogma, and it has been placed in the
14 public domain for educational purposes through
15 the American Heart Association publications, but
16 when one tries to support that statement, and I
17 don't think they offer any reference in that
18 pamphlet, when one tries to support that
19 statement, it keeps coming up that the relative
20 risk is 2, so over and over again, the term
21 synergy, which is undefined by any of those
22 publications, if it means the multitude of
23 things greater than 2, I just can't find it in
24 the literature.
25 Q. But, you disagree with that

Page 158

1 statement as read?
2 A. Yes, indeed.
3 Q. Are you an expert in health care
4 econometrics?
5 A. No, I'm not.
6 Q. Are you going to give testimony in
7 this case about being able to quantify health
8 care costs due to smoking?
9 A. The only testimony I might give, if
10 you asked, was related to a couple publications
11 which I think are in the medical literature,
12 including the New England Journal articles that
13 suggests that there may actually be reduced
14 short term, I'm sorry, reduced long term costs.
15 Q. But, I'm talking about, are you
16 going to be giving expert opinion testimony in
17 this case about the amount and the method of
18 calculating health care costs by the State of
19 Oklahoma due to smoking?
20 A. No, I'm not.
21 Q. Do you know why there would be, if
22 you know, why there would be lower costs, long
23 term costs?
24 A. Long term costs? If the risk of
25 coronary artery disease is higher and mortality

Page 159

1 is higher, then your long term medical care
2 costs are going to be less.
3 Q. Because smokers die prematurely?
4 A. That's correct. There has been an
5 association between cigarette smoking and death.
6 Q. There's a higher rate of mortality?
7 A. Yes.
8 Q. In smokers than non-smokers,
9 correct?
10 A. That's correct.
11 Q. Are you willing to say, Dr.
12 Benditt, that smoking caused the early death?
13 A. No, I think to just clarify based
14 on your question, the several multiple center
15 studies that have been undertaken suggest that
16 there has been an increased frequency of
17 cardiovascular death in studied populations
18 among smokers, however a number of the studies,
19 including perhaps most importantly Mr. Fitt
20 (phonetic) and perhaps even in the pooling
21 project, if I remember correctly, the total
22 mortality differences were not substantial,
23 suggesting that well, if one can identify
24 increased cardiovascular disease-related deaths
25 in smokers as being elevated, total mortality

Page 160

1 isn't necessarily improved.
2 Q. If you will turn to page 6 of that
3 same Exhibit 5, which is the seven day
4 disclosure. Page 6. The paragraph in the
5 middle of the page, it starts with, "The role of
6 the risk factors." Do you see that?
7 A. Yes, I do.
8 Q. Go down to the middle of that
9 paragraph with the sentence that starts with,
10 "Further research is clearly needed." Do you
11 see that?
12 A. Yes.
13 Q. The statement reads, "Further
14 research is clearly needed to identify the
15 factors in cigarette smoke, if any, that may be
16 responsible for cardiovascular effects and to
17 determine the mechanisms by which these factors
18 may alter cellular metabolism and structure."
19 Are you saying that one thing that is needed is
20 to know the various compounds in smoke before we
21 have a clearer picture of causal relationship
22 between smoking and cardiovascular disease?
23 A. Basically the answer is to identify
24 the factors and to ascertain how those factors
25 might on a cellular level participate in

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1 evolving or evoking cardiovascular disease, yes.
2 Q. We're talking about identifying the
3 compounds in cigarette smoke?
4 A. Yes. That's step number 1. And
5 step number 2 is ascertaining how they might
6 participate in disease manifestations.
7 Q. Aren't the tobacco manufacturers
8 the best source of being able to determine what
9 are the compounds in cigarette smoke?
10 MR. CORNFELD: Object, lack of
11 foundation.
12 A. I frankly don't know that they're
13 the best source. I think the important thing is
14 that the technology be made available for
15 researchers, hopefully independent researchers,
16 and the funding be made available to independent
17 researchers to make those measurements and
18 identify the factors involved.
19 BY MR. MIKHAIL:
20 Q. Well, Dr. Benditt, I mean, one
21 source would be to have the technology available
22 for independent outside medical researchers and
23 technical people in laboratories to be able to
24 try to break it down and find out. That's one
25 source, right?

1 A. Yes.
2 Q. But, another source would be for
3 the tobacco manufacturers themselves to reveal
4 what compounds they know of are contained in
5 cigarette smoke, isn't it?
6 MR. CORNFELD: Object, lack of
7 foundation.
8 A. It doesn't seem unreasonable.
9 BY MR. MIKHAIL:
10 Q. And that would enable us, then, to
11 be able to perhaps better determine the
12 mechanisms by which factors may alter cellular
13 metabolism and structure?
14 A. Yes, you have to know the factors
15 and you have to do the appropriate experiments
16 to make those assessments.
17 Q. Do you know if the tobacco
18 manufacturers have done that, to date?
19 A. I can't say what they have done.
20 Q. Do you think they should?
21 MR. CORNFELD: Object, lack of
22 foundation.
23 A. It seems like a reasonable thing to
24 do, to know your product.
25 BY MR. MIKHAIL:

1 Q. You think they should reveal what
2 compounds are in cigarette smoke so we can
3 better determine --
4 MR. CORNFELD: Let me also object
5 because cigarette smoke is cigarette smoke.
6 Anybody can buy a cigarette and smoke it, and
7 see what's in the smoke. There's no secret that
8 a tobacco manufacturer would have about what is
9 in cigarette smoke that no one else can find.
10 MR. MIKHAIL: I'm polite, but you
11 are giving speaking objections again. Make your
12 objection on the record.
13 MR. CORNFELD: I did. That's a
14 ridiculous suggestion to suggest that there's
15 some secret that only a tobacco manufacturer
16 could know about regarding what is in cigarette
17 smoke when you or anyone else can buy a
18 cigarette, smoke it and analyze the smoke.
19 MR. MIKHAIL: I move to strike
20 everything that you've said, and you've done it
21 knowingly, that it's a violation of the Oklahoma
22 rules and admonition of the judge, but I'm going
23 to move on.
24 BY MR. MIKHAIL:
25 Q. Dr. Benditt, I'm going to ask you

1 again. Do you think that in order for us to
2 determine, as you say in your disclosure
3 statement, the mechanisms by which these factors
4 may alter cellular metabolism and structure, and
5 then you say, "Further research is clearly
6 needed to identify these factors in cigarette
7 smoke." I'm saying, do you think the tobacco
8 manufacturers should reveal what factors in
9 cigarette smoke and what compounds in cigarette
10 smoke of their cigarettes are?
11 MR. CORNFELD: Object, lack of
12 foundation.
13 A. If they have that information, I
14 would see no reason why they wouldn't reveal it.
15 BY MR. MIKHAIL:
16 Q. But, do you think they should
17 reveal it, if we were to be able to accomplish
18 what you say here needs to be accomplished?
19 MR. CORNFELD: Let me also object
20 that the components of cigarette smoke have been
21 published widely including by the Surgeon
22 General. There is no secret about this.
23 MR. MIKHAIL: Rick, you're still
24 doing it.
25 MR. CORNFELD: What's the point in

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Page 165

1 asking somebody to reveal what's in cigarette
2 smoke when the information is well-known?
3 BY MR. MIKHAIL:
4 Q. Dr. Benditt, should the tobacco
5 manufacturers -- I'm going to ask the question
6 again. In order for us to accomplish what you
7 say here is clearly needed, should they reveal
8 what they know about the compounds in cigarette
9 smoke of their cigarettes?
10 A. Yes, certainly.
11 Q. All right. Going back to something
12 we talked about, the synergy, one of the things
13 that Dr. Blackburn listed in his opinions in
14 connection with the deposition that you read,
15 opinion number 17 says, quote, "Other strengths
16 of the epidemiological evidence on smoking and
17 cardiovascular disease are," and it lists
18 several of them. The one I'm going to ask you
19 about is number D that says, "Strong interaction
20 of smoking, blood pressure and cholesterol
21 effects." He is saying that the epidemiological
22 evidence on smoking and cardiovascular disease
23 is strong with the interaction of smoking, blood
24 pressure and cholesterol effects. Do you agree
25 or disagree with this conclusion?

Page 166

1 MR. CORNFELD: Charles, can you
2 show him the exact quotation?
3 BY MR. MIKHAIL:
4 Q. Sure, sure.
5 A. Well, he certainly makes that
6 statement. It would have been nice to have
7 known where the data comes from to support that
8 statement.
9 Q. I understand that, but I'm asking
10 you, as an expert opinion, do you agree or
11 disagree with this statement?
12 A. Based on the data I've reviewed,
13 I'd have to disagree with that statement. I
14 might have helped by that remark since you
15 haven't asked another question by saying we
16 haven't defined what interaction means. I think
17 in that statement he did not use the term
18 synergy.
19 Q. The previous statement I read to
20 you, which is number 31, I'll show it to you.
21 "There is a synergistic effect of combining
22 risk factors. Smoking, cholesterol and
23 hypertension synergy equals increased risk." Do
24 you agree or disagree with that statement?
25 MR. CORNFELD: That's repetition.

Page 167

1 Number 17, you asked him about 31 before, and he
2 told you --
3 MR. MIKHAIL: I understand. He
4 said he didn't say the word synergy in paragraph
5 17.
6 MR. CORNFELD: That's because your
7 question had to do with whether he disagreed
8 with paragraph 17. About half an hour ago you
9 asked him about this paragraph, number 31.
10 BY MR. MIKHAIL:
11 Q. Do you agree with number 31, the
12 one I just read to you, there's a synergistic
13 effect of combining risk factors?
14 A. I think the important point is that
15 in that statement you actually define synergy as
16 increased risk. That's not a standard concept
17 of what synergy means. So, in the sense that
18 there's increased risk, there is increased risk
19 when you combine those risk factors, but the
20 relative risk increment remains the same.
21 So, there's not a true synergy.
22 The way you've defined synergy equals increased
23 risk in that statement is I think not
24 misleading, but it's certainly atypical of how
25 we think of what synergy is.

Page 168

1 Q. But, Dr. Blackburn is saying that
2 there's a synergistic effect when you combine
3 smoking, cholesterol and blood pressure. He's
4 saying that, isn't he?
5 A. He uses that word, but then you go
6 on at the end of that very statement to say that
7 synergy equals increased risk. In a previous
8 question, you define synergy quite differently
9 as being greater than the sum of the parts. In
10 my review of the literature, there is no
11 evidence that the risk is greater than the sum
12 of the parts.
13 Q. I'm not suggesting that synergy
14 means the same thing as increased risk. I'm
15 asking you if you agree with this statement that
16 there is a synergistic effect between the three
17 risk factors. Do you agree with that?
18 A. And what I'm saying is according to
19 the way you defined or he defined synergy in
20 that statement, one could agree with him, but in
21 terms of the way one conventionally thinks of a
22 synergistic relationship, one would have to
23 disagree with him.
24 Q. But, what about, we went over this
25 before, but -- I'll just let the record stand as

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1 it stands so that we can cut it short.
2 MR. MIKHAIL: If you all can give
3 me two minutes, I probably can wrap it up in
4 about five minutes or less.
5 THE VIDEOGRAPHER: Going off the
6 video record.
7 (WHEREUPON, A BRIEF RECESS WAS HAD).
8 THE VIDEOGRAPHER: The time is now
9 approximately 1:55 p.m., elapsed time is 4, 15,
10 40.
11 THE VIDEOGRAPHER: Back on the
12 video record. The time is now approximately
13 2:00 p.m. Elapsed time is 4 hours, 20 minutes
14 and 55 seconds.
15 BY MR. MIKHAIL:
16 Q. Dr. Benditt, from the patients that
17 you see, you said that you see approximately 20
18 a week or so?
19 A. More or less, yes.
20 Q. Approximately what percentage of
21 your patient load are Medicaid recipients?
22 A. Medicaid and --
23 Q. Medicaid?
24 A. Medicaid in Minnesota in our
25 practice probably represents ten percent.

1 Q. In your practice?
2 A. Yeah. I'm sort of trying to
3 extrapolate from the practice of me, myself and
4 my colleagues since many of these patients go
5 through several of us, but actually, no more
6 than ten percent.
7 Q. So, if we're using the figure 20,
8 then, a couple of patients a week are Medicaid
9 patients?
10 A. Yes, that would be fair.
11 Q. Approximately what percentage of
12 the Medicaid patients that you see are smokers?
13 MR. CORNFELD: Object to lack of
14 foundation.
15 MR. MIKHAIL: What kind of
16 foundation would you put for that question?
17 MR. CORNFELD: Has he done any
18 analysis to try to figure out what percentage
19 are smokers. That's exactly the kind of
20 foundation. You know, you're asking him off the
21 top of his head, to say, you know, out of two
22 patients a week out of a hundred a year of
23 Medicaid patients, assuming he knows which are
24 Medicaid patients, which are smokers. If you
25 can answer that question, go ahead.

1 BY MR. MIKHAIL:
2 Q. Do you know or an approximate
3 amount, even without a foundation, can you tell
4 me how many patients of the Medicaid recipients
5 that you see, how many of them are smokers, just
6 a rough percentage?
7 A. I have absolutely no idea. In our
8 practice, I probably wouldn't even know a
9 Medicaid patient from a regular paid patient,
10 because that's not the way we see patients.
11 That's held through the business office. The
12 reason I gave you that ten percent is because I
13 wouldn't know in my own specific practice who is
14 who. I don't know what kind of information you
15 hold when you see me. I only know it from a
16 general sense of our overall business.
17 Q. Well, of the patients you see, how
18 many are smokers?
19 MR. CORNFELD: Same objection.
20 Lack of foundation.
21 A. In the state of Minnesota, I would
22 say that we probably are lower than average, but
23 probably in the range of 30 to 40 percent.
24 BY MR. MIKHAIL:
25 Q. And whether or not you know the

1 demographic makeup of the patients that you see,
2 that doesn't prevent you from being able to give
3 an opinion as to causation in cardiovascular
4 disease, does it?
5 A. No.
6 Q. Dr. Benditt, are you presenting
7 yourself in this case to be an expert, or are
8 you going to give any expert opinions in chronic
9 obstructive pulmonary disease?
10 A. No, I'm not.
11 Q. What about chronic obstructive lung
12 disease?
13 A. No.
14 Q. What about pulmonology?
15 A. No.
16 MR. MIKHAIL: Thank you very much.
17 Maybe your counsel has some questions, maybe
18 not.
19 MR. CORNFELD: I don't think so.
20 THE VIDEOGRAPHER: Going off the
21 video record. The time is now approximately
22 2:04 p.m. Elapsed time is 4 hours, 24 minutes
23 and 39 seconds.
24 (Whereupon, the deposition was
25 concluded at 2:04 p.m.)

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INDEX

WITNESS/EXAMINATION
DR. DAVID BENDITT.....3

EXAMINATION
BY MR. MIKHAIL.....3

REQUESTED INFORMATION INDEX
(No Information Requested)

EXHIBITS

Page
BENDITT EXH. 1, July, 1998 Curriculum Vitae.. 28
BENDITT EXH. 2, May, 1994 Curriculum Vitae....31
BENDITT EXH. 3, May 1994 Curriculum Vitae.....35
BENDITT EXH. 4, Benditt's reliance material...74
BENDITT EXH. 5, Seven Day Disclosure.....84
BENDITT EXH. 6, Expert Disclosure.....115

SIGNATURE OF DEPONENT

I, the undersigned, DR. DAVID BENDITT do hereby certify that I have read the foregoing deposition and find it to be a true and accurate transcription of my testimony, with the following corrections, if any:

PAGE LINE CHANGE REASON

DR. DAVID BENDITT

NOTARY & REPORTER'S CERTIFICATE

I, Joan M. Anderson, hereby certify that prior to being examined, this witness, DR. DAVID BENDITT, was duly sworn to testify the whole truth, and nothing but the truth relative to said cause;

That said deposition, consisting of 176 pages of typewritten material, was taken down by me in Stenograph at the time and place therein named, and was thereafter reduced to computer-aided transcription under my direction; that the reading and signing of the deposition was not waived by the witness and respective counsel;

That the foregoing deposition is a true record of the testimony given by said witness;

That the cost of the original has been charged to the party who noticed the deposition, and that all parties who ordered copies have been charged at the same rate for such copies;

I further certify that I am not interested in the outcome of this action.

WITNESS my hand and seal at Minneapolis, Minnesota this of October, 1998.

JOAN M. ANDERSON
Certified Shorthand Reporter

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